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ABSTRACT

This report constitutes the response by the Department of Health, Education, and Welfare (DHEW) to 1977 and 1978 Congressional directives to assess immigrants' access to health care and the impact of immigrants on public health services and resources. Areas covered in the report are: (1) the primary health care needs of immigrants, including screening upon entry, prevalence of various health problems among immigrant populations, mental health, and socioeconomic factors related to health: (2) the accessibility of primary health care services to immigrants, particularly as related to their lack of knowledge regarding the health care system, cultural and linguistic barriers, the effects of poverty and discrimination, and financial barriers to health care: (3) the impact of undocumented aliens, refugees, and legal immigrants on public health services: and (4) current efforts by individual agencies within DHEW to provide adequate services for immigrant populations. Recommendations are made regarding the improvement of research and data collection and the delivery of services. Tables and a description of the study's methodology and data sources, as well as a bibliography on some issues related to immigrants and health are also included in this report. (GC)

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PRIMARY HEALTH CARE NEEDS OF IMMIGRANTS

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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INTRODUCTION

On November 10, 1978, in section 116(a) of the Health Services and Centers Amendments of 1978, Public Law 95-626, Congress directed the Secretary of the Department of Health, Education, and Welfare to submit a report to Congress on the primary health care needs of immigrants. Specifically, P.L. 95-626 provides that:

> "...the Secretary of Health, Education, and Welfare (hereinafter in this section referred to as the "Secretary") shall submit to Congress a special report on the primary health care needs of immigrants. The report shall be developed through consultation with the Commissioner of the Immigration and Naturalization Service, with leaders in the health care area, and with representatives of immigrants. The report shall contain (1) an assessment of the access of (and barriers to) immigrants in receiving health care services, (2) an assessment of the health needs of such immigrants, and (3) specific recommendations for the development of a national strategy to address these needs taking into account the fact that significant numbers of immigrants reside in a select number of specific States."

On May 18, 1977, in the Departments of Labor and Health, Education, and Welfare and Related Agencies 1978 Appropriations Report No. 95-283, the Senate Committee on Appropriations also expressed:

> "...deep concern that the continuing disproportionate concentration of immigrants in a few select States such as Hawaii will result in significant adverse consequences and an undue hardship for the public health authorities and resources of those States."

Accordingly, the Committee directed the Bureau of Community Health Services (BCHS), Health Services Administration (HSA), Public Health Service (PHS), to review its current efforts to ensure and provide adequate health services for the immigrant population and to report to the Committee its recommendations for additional means of fulfilling the Federal Government's responsibility to ensure that these individuals receive adequate health services.

Objectives

The following report constitutes the response to the two congressional directives. The objectives of this document are as follows: 1) to assess the access of (and barriers to) health care services for the immigrant population; 2) to assess the health care needs of immigrants; 3) to review current efforts by the Department, including BCHS, to provide the immigrant population adequate health care services; and 4) to make specific recommendations to ensure that these individuals receive adequate health services.

Methodology

To accomplish these objectives, existing literature on the primary health care needs of immigrants was reviewed. Interviews were held with persons who are involved with issues related to the social service and health care needs of immigrants. Federal, State, and local government agencies were contacted. The Staff Report of the Interagency Task Force on Immigration Policy 1/ was used in developing sections of the report, and additional information made available by experts in the field of immigrants also was used. Finally, an initial draft of this report was reviewed and commented upon by a select group of experts on immigrant health at a meeting held in Dallas, Texas, in June 1979 (see Appendix A). A bibliography of reference materials used in preparing this report is included in Appendix B.

Data and Information

A major difficulty in assessing the health needs and impact of immigrant populations is a lack of hard data, specifically on the primary health care needs of immigrants. The literature search found that, although some studies have been conducted on the mental health care needs of immigrants, little research has been conducted on the physical health care needs. 2,3/ A few studies have produced information on specific medical conditions in immigrant populations (e.g., Reichman, et. al. 4/); however, the general health status and the health care needs of immigrants have yet to be fully explored.

1/ Staff Report of the Interagency Task Force on Immigration Policy. Departments of Justice, Labor, and State, March 1979. (This report was the source of data in the sections on "Trends in Population Distribution" and on "Rights of Aliens." This citation will be shortened to Interagency Task Force for this document.)

2/ Weaver, Jerry L., Ph.D. National Health Policy and the Underserved: Ethnic Minorities, Women and the Elderly. St. Louis: C.V. Mosbey Co., 1976.

3/ Bernal, Martha E. and Jamieson, Karen J. "Caretaker-Client Ethnicity Effects," University of Denver. Paper presented at meetings of the American Public Health Association, Los Angeles, 1978.

4/ Reichman, Lee B. et. al., Ad Hoc Committee of the Scientific Assembly on Tuberculosis, "Tuberculosis in the Foreign Born." American Review of Respiratory Disease, Vol. 116: 561-564, 1977.

Only one State, Hawaii, collects data on the health status of all immigrants 5/, although certain States, such as Florida, have produced studies on specific immigrant populations. 6/ Persons working closely with recent immigrants have contributed much to the data available for this report.

Because of the lack of available data on immigrants, this report relies heavily on existing data pertaining to the health care needs of ethnic minorities. In particular, the report refers extensively to data on Asians and Hispanics--two ethnic groups which account for a substantial proportion of recent immigration into the United States. Moreover, a relatively high percentage of persons of Asian or Hispanic ancestry in the U.S. are foreign born. This report assumes that data on a specific ethnic group generally may be applicable to immigrants of that ethnic background.

It should be noted that the use of ethnic data in assessing the health care needs of immigrants has its limitations. Ethnic categories such as "Asian" or "Hispanic" include persons of varying national origins. For instance, Asians include Chinese, Japanese, Filipinos, Koreans, Vietnamese, Laotians, Burmese, and Thai, while Hispanics include persons from a variety of Latin American countries. What applies to one Asian or Hispanic subgroup may not apply to another, e.g., the health status of one Hispanic subgroup, Cubans, may differ from another, Mexicans.

In sum, caution must be exercised in drawing generalizations from one immigrant or ethnic group to another immigrant or ethnic group. While there are some health needs common to immigrants in general, all immigrant health care needs are not the same across the board. The data on specific ethnic or immigrant groups used in this report are meant to be illustrative of the scope of problems faced by immigrants, and are not to be generalized to all immigrant groups.

5/ Burch, Thomas. Hawaii State Department of Health, Research and Statistics Office. Health of Residents, Immigrants, and Immigrants in Hawaii, 1973: A Report Based on the Hawaii Health Survey. April 1977.

6/ Task Force on Human Services to Haitian Aliens, Knight, Dewey W., Chairperson. Human Services to Haitian Aliens, Miami, Florida: Metropolitan Dade County Manager's Office, 1978.

Definitions of Terms

The process of data gathering for this report revealed that there is a range of possible definitions for the terms "immigrant" and "primary health care."

Alien

An alien is defined, under the Immigration and Nationality Act, as any person in the United States who is not a citizen or national of this country. The term, alien, further is divided into the following major categories:

1. Immigrant: An alien lawfully admitted who is not a citizen or national of this country and who has been admitted with the expectation that such an individual will reside permanently in the United States.

2. Non-immigrant: An alien lawfully admitted for a temporary period of time, such as a student and a temporary worker.

3. Refugee: An alien paroled into the United States as a conditional entrant who is fleeing racial, religious or political persecution from any Communist or Communist-dominated country, or from the general area of the Middle East, or from Indochina.

4. Undocumented (illegal) alien: An alien who unlawfully entered the United States, or more accurately, who is in the United States without entry status. 7/ Hereafter, this category of alien will be referred to in this report as an undocumented alien.

The Immigration and Naturalization Service's (INS) definition of immigrant is as follows:

> "any alien residing in the United States or in its territories with a legal, permanent resident visa, including, but not limited to, refugees."

This definition excludes non-immigrants, undocumented aliens, and United States nationals such as American Samoans, who are not citizens.

7/ Interagency Task Force, op. cit., pg. 53-71.

Technically, an alien's status on entry to the United States affects that individual's access to available primary health care services. Eligibility for certain public health and social services is based, in part, on the alien's status and on the length of time an immigrant has been in the United States. Immigrants and refugees generally experience rights and privileges more similar to those of American citizens than do non-immigrants or undocumented aliens. 8/ Further discussion of these distinctions is found in the section of this report on "financial barriers" to health care.

A broad definition of "immigrant," which includes undocumented aliens and United States nationals as well as "any alien residing in the United States or in its territories with a legal, permanent resident visa, including, but not limited to, refugees," is used in this report. This definition, which expands upon the narrower INS definition, permits discussion of the primary health care needs of undocumented aliens and nationals such as American Samoans who experience adjustment problems and place demands on the health care system in a manner similar to legal immigrants. 9/

Primary Health Care

There are many definitions of and concepts about what constitutes primary care. For the purposes of this report, the definition found in the Appendix to 42 CFR Part 57, Subpart Y, Guidelines for Nurse Practitioner Training Programs, will be used. It states:

> "Primary health care" means care which may be initiated by the client or provider in a variety of settings and which consists of a broad range of personal health care services including:
>
> (1) promotion and maintenance of health;
> (2) prevention of illness and disability;
> (3) basic care during acute and chronic phases of illness;
> (4) guidance and counseling of individuals and families; and
> (5) referral to other health care providers and community resources when appropriate.
>
> In providing such services (i) the physical, emotional, social, and economic status, as well as the cultural and environmental backgrounds of individuals, families, and communities (where

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8/ Ibid, pg. 63.

9/ Yuen, George and Junasa, Bienudo. "Preliminary Report: Immigrant Health in Hawaii" (unpublished paper presented at the Dallas, Texas, Conference on "The Primary Health Care Needs of Immigrants") June 1979, pg. 7.

applicable) are considered; (ii) the client is provided access to the health care system; and (iii) a single provider or team of providers, along with the client, is responsible for the continuing coordination and management of all aspects of basic health services needed for individual and family care.

The specific personal health care services needed to meet a client's primary health care needs have been defined according to section 329 and section 330 of the Public Health Service Act, the statutory language for migrant health centers and community health centers.

According to section 330, term "primary health services" means:

(1) services of physicians and, where feasible, services of physicians' assistants and nurse clinicians;
(2) diagnostic laboratory and radiologic services;
(3) preventive health services (including children's eye and ear examinations to determine the need for vision and hearing correction, perinatal services, well child services, and family planning services);
(4) emergency medical services;
(5) transportation services as required for adequate patient care;
(6) preventive dental services; and
(7) pharmaceutical services, as may be appropriate for particular centers.

Section 330 further requires supplemental health services to be provided either on site or by referral, as may be appropriate for each center, for the adequate support of primary care services.

According to section 330, the term "supplemental health services" means services which are not included as primary health services and which are:

(1) hospital services;
(2) home health services;
(3) extended care facility services;
(4) rehabilitative services (including physical therapy) and long-term physical medicine;
(5) mental health services;

(6) dental services;
(7) vision services;
(8) allied health services;
(9) therapeutic radiologic services;
(10) public health services (including, for the social and other nonmedical needs which affect health status, counseling, referral for assistance, and followup services);
(11) ambulatory surgical services;
(12) health edcation services (including nutrition education); and
(13) services which promote and facilitate optimal use of primary health services and the services referred to. . . (above) including, if a substantial number of the individuals in the population served by a community health center are of limited English-speaking ability, the services of appropriate personnel fluent in the language spoken by a predominant number of such individuals.

In addition, section 329(a)(1)(D) and section 330(a)(4) require the provision of environmental health services, as appropriate.

The "primary" and "supplementary" health care services, just described, generally would be needed by any population group, including immigrants.

Statutory language found in section 329(a)(1)(E) and (F) of the Public Health Service Act, for Migrant Health Centers, further requires that health care services for migrant or seasonal agricultural workers and their families include infectious and parasitic disease screening, and prevention of excessive pesticide exposure. A significant number of Mexican immigrant migrant workers and other immigrant populations are frequently employed in low-skilled jobs, often in a hazardous work environment. Therefore, the services itemized in section 329 are included in this discussion of primary health care services for immigrants.

Persons providing health care to immigrants have specifically recommended that mental health services, public health services, bilingual/bicultural services, and outreach community services are essential services in any system providing health care to immigrants. 10/

ASSESSMENT OF THE PRIMARY HEALTH CARE NEEDS OF IMMIGRANTS

There are numerous factors which affect the primary health care needs of immigrants. These factors include their health status at entry to the United States, prevalent conditions and diseases, the psychological effects of immigration, and their socioeconomic status.

Screening Upon Entry

To gain entry to the United States, all immigrants, including refugees, must be screened for a variety of diseases and conditions which, according to immigration law, may prevent them from emigrating to the United States. The diseases and conditions are infectious tuberculosis, infectious leprosy, venereal disease, mental retardation or insanity, and drug abuse or alcohol addiction.

Physicians and public health advisors from the Center for Disease Control (CDC) have been assigned to the American embassies in Thailand, Indonesia, Malaysia, Hong Kong, and Singapore to assist in the screening of United States-bound refugees. The health screening determines whether a refugee will be allowed to enter this country. Once medically cleared overseas, refugees travel to the United States carrying their medical records, including chest X-rays. All refugees are given a visual inspection and their medical records are reviewed upon arrival at United States ports of entry by CDC quarantine officers posted there. If necessary, refugees may be quarantined, or assisted in securing access to emergency medical treatment as required.

Assessments of screening activities indicate that the majority of refugees are free of significant contagious diseases. Where illness is present, it is most likely to represent a personal rather than public health problem; and, to date, no serious public health problem linked to refugees has developed anywhere in the United States.

10/ Reyes Report on the "Conference on the Primary Health Care Needs of Immigrants, Dallas, Texas, June 1979." Report date: July 13, 1979, pg. 21.

Prevalence of Various Health Problems Among Immigrant Populations

An examination of the health status of immigrants is the initial step in an assessment of their primary health care needs. A number of sources have documented the difficult lives of many immigrant populations. These populations share common medical problems, including malnutrition, low resistance to infection, dental and other oral diseases, and greater susceptibility to and incidence of communicable diseases, such as tuberculosis. In addition, these populations experience a high incidence of teenage and high-risk pregnancies. 11/

While there are certain diseases and health problems which generally are common to immigrant populations, there also are health problems that are unique to specific immigrant groups. For example, Asian immigrants in Hawaii experience a high incidence of tuberculosis (80 percent of tuberculosis cases are found in the foreign-born); skin infections; iron deficiency anemia; intestinal parasites; middle ear diseases; leprosy; untreatable major congenital diseases; oral diseases (twice as prevalent among immigrants); and mental health problems, such as severe depression. 12/

A study of foreign-born immigrants in Hawaii from 1972-1974 reported a lower incidence of heart disease, arthritis, rheumatism, and hypertension than that of the native population. 13/

Another survey of various Asian populations in low-income neighborhoods noted that the following diseases were the major health problems of each population: 1) Chinese, upper respiratory infections; 2) Japanese, heart or circulatory disease; 3) Korean, dental problems; 4) Filipino, upper respiratory infection and heart disease; and 5) Samoan, bone and muscle problems. 14/

11/ Human Services to Haitian Aliens, op. cit., 1978.

12/ Yuen and Juanasa, op. cit., pg. 8.

13/ Burch, Thomas, M.D. "Public Health Nursing Services to Immigrants and Residents in Hawaii, 1976-1977 Fiscal Year," Report #21, Research and Statistics Office, Hawaii State Department of Health, March 1978.

14/ U.S. Department of Health, Education, and Welfare, Office of the Secretary, Office of Special Concerns, Division of Asian American Affairs. Asian American Field Study: Summary of the Data, May 1977, pg. 7-9.

Vietnamese refugees report a high incidence of conjunctivitis; impetigo; gastrointestinal disorders; hepatitis, types A and B (which is a concern for American dentists as it is communicable during treatment of dental problems); malaria; tuberculosis; and parasitic infections. 15/

Mexican-American immigrants report a high incidence of tuberculosis; vitamin deficiencies and malnutrition; infectious diseases; diabetes; pneumonia; a high infant mortality rate; 16,17,18/ and a high number of fatal accidents. 17/ Mexican-Americans, like most poor populations, are less likely to die of vascular diseases, heart disease, or neoplasms as they die at a younger age. 18/ Puerto Ricans, in addition, suffer from a variety of parasitic diseases. 19/ Cubans represent a relatively older population, averaging 37 years of age, compared to 20 years of age for the Mexican-Americans. 20/ As a relatively older population, Cubans have a higher incidence of degenerative diseases.

Mental Health

In addition to physical health problems, mental health problems are prevalent among immigrants. Feelings of alienation, anxiety, and depression are common among immigrants experiencing adaptation crises. Whether forced or voluntary, the precipitous departure from home and homeland can evoke insecurity and anxiety about the new and the unknown. 21/

15/ Silverman, M. "Vietnamese in Denver: Cultural Conflicts in Health Care," Paper presented at George Mason University, October 25, 1979.

16/ Ross, Stanley. Views Across the Border: The United States and Mexico, University of New Mexico Press, Albuquerque, 1978, pg. 242.

17/ Bullough, Bonnie and Bullough, Vern. Poverty, Ethnic Identity and Health Care, Meredith Corporation, 1972, pg. 75.

18/ Burma, John, ed. Mexican Americans in the United States: A Reader, Schnenkman Publishing Company, Inc., New York, 1972, pg. 348.

19/ Bullough and Bullough, op. cit., pg. 78.

20/ Ibid.

21/ Segal and Lourie, Report on "Mental Health Status of Refugees," Report to NIMH, Guam, June 8, 1975 (unpublished report).

Especially vulnerable subgroups exist among the immigrant and refugee populations, including the aged, young children and adolescents, illiterate persons, and individuals with neither family nor friends. For refugees and immigrants, factors such as racism, 22, 23/ poverty, 22/ urban lifestyle, 22/ and cultural differences 22, 23/ can contribute to mental problems.

Most refugees entering the United States face a broad range of both acute and chronic problems of adaptation and adjustment. A report on the mental health needs of Vietnamese refugees noted that feelings prominent among them are grief and depression, anxiety about the welfare of separated family members, panic over an uncertain future, feelings of remorse and guilt, confusion, and a growing sense of bitterness, disappointment and anger. The emotional burdens carried by these refugees often are reflected not only in a general sense of malaise, fatigue, and psychosomatic complaints, but by evidence of lethargy, withdrawal and seclusion, and expressions of melancholy. 24/ Other possible outcomes of these untreated cases of depression and anxiety are alcohol and drug abuse, and spouse and child abuse. 23,25/ Voluntary organizations and agencies supporting refugee employment and training projects have reported that emotional problems prevent significant numbers of refugees from securing or holding gainful employment. The national objective of refugee self-sufficiency can not be achieved for such refugees unless mental health and emotional problems are addressed.

These mental health problems are not confined to the refugee population. The incidence of mental health disorders, such as severe strain, suicide, and conditions requiring institutionalization, is greater among immigrants than among native-born Americans. 26/ Available data suggests that the incidence rates for mental breakdown are considerably higher for refugees. 27/

22/ The President's Commission, Mental Health: 1978, Appendix: Volume III, Subpanel on Asian/Pacific Americans, pg. 773-819, and Subpanel on Hispanic Americans, pg. 902-951.

23/ Burma, John, ed. Mexican-Americans in the United States: A Reader, Karno, M., et. al., "Perception of Mental Illness in a Mexican-American Community," pg. 343-354.

24/ Segal and Lourie, op. cit., pg. 6.

25/ Ibid., pg. 5.

26/ The Determinants and Consequences of Population Trends, UN: Department of Economic and Social Affairs, Population Study #50, 1973, pg. 261.

27/ Ibid.

Certain subgroups within the immigrant population suffer greater risk of mental illness than do others. High-risk Asian immigrant subgroups would include "1) Indochinese 'refugees'; (2) American servicemen's wives who are Asian or Pacific American; (3) recent immigrants, especially the elderly and children; 4) people undergoing rapid cultural change (from parts of Hawaii, Samoa, Micronesia, and the Trust Territories); and 5) individuals with multiple problems, such as physical and developmental problems concurrent with specific mental health problems." 28/

The Mexican-American population at greatest risk would be those suffering from a "chronically depressed socioeconomic status, marked by a low education level, with a high degree of functional illiteracy, crowded and deteriorated housing, a high incidence of communicable disease, and limited employment opportunity." 29/ These characteristics are not uncommon to recent Mexican-American immigrants.

Children and second-generation immigrants also are at-risk for mental health problems. Because of having two cultures with which to relate, the one at home and the one at school, immigrant children often manifest conflict which can result in cultural disintegration or an increased rate of crime." 30/

"The most pervasive mental health problem confronting Asians, Pacific Americans, and Hispanic populations is racism. It adversely affects their psycho/economic status and is manifested by discriminatory acts." 31/

28/ Mental Health: 1978, op. cit., pg. 704.

29/ Burma and Karmo, op. cit., pg. 348.

30/ The Determinants and Consequences of Population Trends, op. cit., pg. 260.

31/ Burma and Karmo, op. cit., pg. 348.

Socioeconomic Factors

The low socioeconomic level of most immigrants appears to contribute significantly to their medical problems. A study conducted by the New Mexico State Health Agency and the CDC in 1976 demonstrated that a positive correlation exists between socioeconomic level and health. Health indicators, such as infant mortality rates and the incidence of both tuberculosis and gonorrhea, were inversely correlated with socioeconomic level. 32/

While there are immigrants of high or moderate socioeconomic status, most compare with the socioeconomic status of minorities, which is generally lower than the population as a whole. Table I presents a breakdown of some specific socioeconomic characteristics of the various major minority groups. 33/

The table illustrates that the Hispanic population has a greater degree of poverty than the Asian population. It further illustrates that Asians have two times the number of families with incomes greater than $15,000 per year than do black or Hispanic families. However, 50 percent of the Asians in the United States have immigrated since 1970, and the percentage of low-skilled, poor Asian immigrants has significantly increased, especially as a result of the Indochinese refugees admitted in the past year.34/ The changing economic profile of Asian immigrants will slowly change the ratio of high-income to low-income Asians. Although their total numbers are considerably smaller than the Hispanic immigrant population, low-income Asian immigrants are affected by the same socioeconomic barriers to availability of services as are Hispanic immigrants. For example, in "New York City's Chinatown the mean family income is $7,845 and approximately 20 percent of all families are below the poverty level. The 1972-75 specific-cause average death rates for this group indicated a significantly low health status. Moreover, the hypertensive cardiovascular crude death rate in Chinatown was double that of New York City and the death rate for tuberculosis was about eight times that of New York City." 35/

32/ (A Joint Effort of the United States, Mexico, and the Pan American Health Organization) Review of Health Situation: United States - Mexico Border and Recommendations for Bilateral Cooperation, 1978.

33/ Health - United States: 1979, Table C, pg. 7.

34/ Information provided by Elena Yu, Visiting Researcher, National Center for Health Statistics, February, 1980.

35/ Information provided by Alan Chen, Assistant Director, Chinatown Health Clinic, New York City. In a letter dated February 26, 1979.

"The proportion of black families with less than $5,000 a year is about three times the proportion of white families; for Hispanics, the proportion is about two times that for white families not of Hispanic origin." 36/ "Poverty underlies and aggravates the health problems of Mexican-Americans and is exacerbated by the rapidly increasing population rate." 37/

In Texas, the poverty rate for rural Mexican-Americans is 50 percent and for urban 33 percent, compared to 54 percent (rural) and 36 percent (urban) for blacks, and 16 percent (rural) and 9 percent (urban) for whites. 38/ Seventy percent of the unskilled and semiskilled workers in border States (Texas, New Mexico, Arizona, and California) are of Mexican origin. 39/ Such poverty contributes significantly to the health problems of Mexican-Americans. 40/

Environmental health hazards resulting from low income, such as crowded housing and poor sewage disposal, further contribute to a low health status. Such hazards, however, are not restricted to Chinatowns or Hispanic barrios, but also exist in new immigrant communities and among other disadvantaged populations. "Immigrants, common in the rural areas of the Southwest, though not affected by dense housing, experience overcrowded, inadequate housing, inadequate supplies of water, and long-term exposure to atmospheric or industrial pollutants." 41/ Newly arrived immigrants tend to settle into communities that are culturally and linguistically similar to their own national origin. 42/ This factor adds to the crowding. Inability to speak English, coupled with nontransferable job skills, prevents many immigrants from seeking other than entry level, low-skilled jobs. Tables 2 and 3 illustrate both recent and projected occupational distributions of immigrants as compared to the native born and foreign born.

36/ Health - United States: 1979, pg. 16.

37/ Ross, Stanley, op. cit., pg. 17.

38/ Texas Department of Community Affairs. "Community Action in Texas Has as Its Purpose to Help People Help Themselves." Austin, Texas, June 1977.

39/ Ross, Stanley, op. cit., pg. 11.

40/ Ibid., pg. 17.

41/ Review of Health Situation: United States-Mexico Border, op. cit., pg. 24.

42/ The Determinants and Consequences of Population Trends, op. cit., 1973.

Low income relegates immigrants to the poorer quality housing. As a result, the crowded, poor conditions of older immigrant communities worsen as newly arrived immigrants settle in these areas. The demand for housing, environmental protection, social and health care services consequently rises in direct proportion to increases in immigrant population.

ASSESSMENT OF THE ACCESSIBILITY OF PRIMARY HEALTH CARE SERVICES FOR IMMIGRANTS

Both Asian and Hispanic immigrant populations underutilize the existing health care system. This underutilization is caused by various barriers to access to health care such as: lack of knowledge of the existing system, cultural and linguistic barriers, and financial barriers.

Lack of Knowledge of the Existing Health Care System

Most recently arrived immigrants are unfamiliar with the health care system in the United States. "Safety, shared experiences, and common language within their communities tend to inhibit elderly Asian and newly arrived immigrants from going beyond their immediate boundary for services." 43/

Mexican-American and other immigrant populations perceive their communities, the "barrios" and "colonias," in a manner similar to the perception of the Asian immigrant. 44/ If a health care service provider is not readily accessible to these communities, the community "boundaries" often prevent access to health care services. For example, the immigrants' knowledge of our health care system is usually supplied by friends, family, and sponsors from within the community. Therefore, the depth of knowledge imparted is only as complete as the suppliers' knowledge of the support services, and appropriate access points often are not communicated. Health care services outside the community catchment area are not as likely to be used by immigrants as those within, due in part to lack of knowledge about them.

43/ Mental Health - 1978, op. cit., pg. 791.

44/ Clark, Margaret. Health in the Mexican-American Culture: A Community Setting, Los Angeles: University of California Press, 1970, pg. 15.

Cultural and Linguistic Barriers

The immigrants' health care practices in their country of origin are a key factor to utilization of and access to Western health care systems. Culturally based concepts of health care persist in the thinking of immigrants, even in second - and third-generation Americans, continue to influence their health behavior. 45/ Frequently, for immigrants, the last culturally based behaviors to change are their dietary and health habits. 46/ Reliance on folk medicine is common for most immigrant populations, regardless of country of origin. 47/ Many reports have documented folk medicine practices among immigrant populations as diverse as Vietnamese, Chinese, Filipinos, Mexicans, and Haitians. 48/

It is likely that immigrants will practice or receive native medical treatment, not merely as an alternative to insensitive public care, but because it is part of their cultural system, and is an obvious and natural choice for them. It is often the American medical system that is the "alternative" source of treatment, particularly for the minor, chronic conditions which are symptomatic of the more serious disorders mentioned elsewhere in the text as usually prevalent among immigrant groups. This is especially true for new arrivals.

As a result, these populations often come under a physician's care only when disease is far advanced. Their utilization of mental health services, primary health care services, and especially hospitals is delayed in part because of fear of these unfamiliar medical practices. 49/ Various immigrant populations seek traditional self-care therapies prior to seeking folk medicine providers (curanderos, healers, etc.) and only as a last resort do they seek professional medical attention. In a study of Vietnamese living in Denver, 80 percent of refugees wait approximately 5 days after presentation if symtoms before seeking care. Only 10 percent of these refugees sought followup care when ill. 50/ Mexican immigrants similarly proceed from self-care to curandero and, finally, to the physician. 51/

45/ Ibid., pg. 163 and 209.

46/ Yu, op. cit.

47/ Yuen, op. cit., pg. 20; Ross, op. cit., pg. 274; and Clark, op. cit., pg. 209.

48/ Ibid.

49/ True, Reiko Homma, "Health Care Issues for Asian Americans" DHEW/PSH/ADAMHA (Unpublished report), July 1979, pg. 4.

50/ Silverman, M., op., cit. pg. 5.

51/ Burma, J., ed. Mexican-Americans in the United States: A Reader. Madsen, William, "Society and Health in the Lower Rio Grande," op. cit., pg. 332.

Many practitioners in the United States have no knowledge of the cultural health beliefs of immigrants, and this prevents them from adequately assessing the significance of the immigrants' complaints and folk remedies. Other cultural differences between the practitioners and the immigrant patient, such as proper decorum, modesty, reserve and control of the expression of fear and pain, may further prevent delivery of adequate health care. 52/

Obstacles to credentialing and licensure of immigrant health care providers and the lack of available culturally based health care services affect the overall availability of care for immigrants. 53/ The lack of bilingual/ bicultural health care personnel represents a serious barrier to service utilization by immigrants. The inability to speak English is a major obstacle for immigrants as most practitioners are not bilingual. As a result, even the simple exchange of information is very difficult without an interpreter. Often, interpreters are not available at crucial times in the delivery of care. These events further isolate the immigrant, lead to fragmentation of care, and contribute to the immigrant's seeking folk medicine over Western medicine.

Culture of Poverty: Prejudice and Discrimination

For indigent populations, including many immigrants, health can be affected by socioeconomic factors such as poverty, undereducation, and poor access to transportation. The psychological characteristics of poverty also have important consequences for health. 54/ Fatalism, helplessness, dependence, and feelings of inferiority are often prevalent in these populations. Time orientation is concentrated in the present, not the future as is the case of the middle class. This sense of alienation from the mainstream affects ability to plan for the future, and often is demonstrated by a lack of practice of preventive health care. 55/

Prejudice and discrimination by the larger community, both institutional and personal, compound these poverty-linked problems and act as additional barriers to health care. 56/ Prejudice and stereotyping also can contribute to an insensitivity on the part of persons providing services to immigrants, which prevents the immigrant from receiving adequate health care.

52/ True, op. cit., pg. 5.

53/ Mental Health - 1978, op. cit., pg.794.

54/ Bullough and Bullough, op. cit., pg. 54.

55/ Ibid.

56/ Ross, Stanley, op. cit., pg. 274.

Financial Barriers

The lack of financial resources for immigrants poses a major barrier to utilization of and access to services, and is another reason they seek folk medicine over Western medicine. 57/

Employment

The cultural values of many immigrant groups emphasize employment, no matter how menial, and deplore the receipt of charity, which results in low employment and high underemployment. 58/ "English proficiency level is directly correlated to labor force participation and earnings level and inversely to unemployment." 59/

With a limited budget, shelter, food and clothing usually take precedence over health care for the immigrant. For example, health care ranked fourth in a list of financial priorities for a group of Mexican-born immigrants. 60/ Hawaiian immigrants also experience health care that often is episodic and crisis-oriented for financial reasons alone. 61/ In part, due to inadequate finances, minor conditions usually become major health problems before treatment is sought. Hospitalization can be a cause of financial crisis and can increase feelings of isolation and helplessness experienced by immigrants. 62/

Insurance

As is true for many citizens, insurance may not be the answer to access to health care for many immigrants. Businesses which employ low-income workers often do not offer health insurance as a benefit to their employees. For low-income workers, the cost of employer-shared insurance premiums may be more than they can afford. Even when insurance is included as a benefit of employment, coverage may be minimal, with reimbursement for care of major illnesses only, and not for preventive, ambulatory primary care services. Additionally, some immigrants fear loss of employment if they use their benefits or take

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57/ Human Services to Haitian Aliens, op. cit., pg. 19.

58/ Moulton, David M., "The Socioeconomic Status of Asian American Families in Five Major SMSAs," March 9, 1978.

59/ Annual Report on the Indochinese Refugee Assistance Program, op. cit., December 1979.

60/ Lee, Isaiah C., Dr., P.H., Medical Care in a Mexican-American Community, Los Alamitos, CA: Hwong Publishing Co., 1976, p. 10.

61/ Yuen and Juanasa, op. cit., pg. 13.

62/ Ibid., pg. 14.

time from work to seek health care. Most insurance benefit packages are extremely complex and, as a result, are difficult to fully understand. Lack of understanding is not just a result of the language barrier. In many Asian countries, medical insurance is an unfamiliar concept as it is not provided to nor expected by the population. 63/

Private Health Care

Without insurance, private health care services, with fees ranging from $8 to $50 per visit plus the cost of tests and prescriptions, are not financially accessible to low-income people, including immigrants. 64/ In addition, private nonprofit health care facilities discourage utilization by persons unable to reimburse them for services as they do not have the capability of absorbing many non-payors. 65/

Public Health Care

Eligibility for public health care services varies according to the immigrant's status at the time of the need for such services. Aliens, whether legally admitted or undocumented, can acquire Medicare coverage assuming they have insured and eligibility status for Social Security benefits. Otherwise, undocumented aliens are ineligible for either Medicare or Medicaid. Aliens, age 65 or older, who have been lawfully admitted for permanent residence in the United States for at least 5 consecutive years may obtain Medicare coverage on a voluntary buy-in basis if they do not qualify on the basis of Social Security status. Because few recent immigrants qualify on the basis of Social Security status, the 5-year residency requirement, in practice, prevents most elderly immigrants from receiving Medicare coverage.

Refugees are eligible for Medicare and Medicaid coverage, and the Federal Government reimburses States for the medical assistance provided to refugees who have been in the United States 3 years or less. Most State Medicaid eligibility requirements consider the applicant's level of income, assets, residency, and family composition. The majority of immigrants, not unlike other Americans, are ineligible for publicly supported health care and must rely on employer-shared insurance or private funding to pay for health services.

63/ Yu, op. cit.

64/ Yuen and Juanasa, op. cit., pg. 17.

65/ Ibid.

Some public health service programs, such as those administered by BCHS/HSA, do not have citizenship-status eligibility requirements and are administered with sliding-scale fee systems. There are limits, primarily budgetary, on the number of medically underserved, including immigrant populations, to whom they can provide services.

The extent of the utilization of public health services by immigrants is not known. Again, this lack of knowledge about service utilization is in part due to the fact that ethnic-specific and immigrant-specific data are just beginning to be collected.

Legal Issues: Sponsorship

Legal-immigrant relatives of undocumented aliens have been reluctant to use public health services for fear their relatives will be "repatriated." 66/ Deportation provisions, such as "public charge," depending on public assistance, and documented mental illness, although little used, cause some immigrants to fear using public health services. 67/ These perceptions of rights and eligibility for public health services act as a barrier to health care for certain immigrants. Immigrants who may be eligible are reluctant to apply for assistance for fear that it will hinder petitions for the immigration of family members who are still in their native country.

In order for immigrants to sponsor other relatives to the United States, 68/ they must demonstrate the ability to take financial responsibility for them. Utilizing public health services may not enhance the immigrants' ability to sponsor other relatives. A final point is that if an immigrant's sponsor does not take financial responsibility for the immigrant, the immigrant has no recourse but to provide for his own care or to seek public support. 69/

66/ Yuen and Juanasa, op. cit., pg. 12.

67/ Ibid., pg. 23.

68/ Ibid., pg. 28.

69/ Ibid., pg. 16.

ASSESSMENT OF THE IMPACT OF IMMIGRANTS ON PUBLIC HEALTH CARE SERVICES

As discussed previously, there is little hard data on immigrants, their health needs, and health care utilization. Without such data, it is difficult to assess the impact of immigrants on public health care services.

Between 1950 and 1970, the United States admitted 6.9 million legal immigrants. The 1965 Amendments to the Immigration and Nationality Act abolished the national origins quota system that had favored Northern and Western European immigration. As a result, following 1965, immigration shifted to those groups which had been severely restricted for the past four decades, and large numbers began to enter from Southern and Eastern Europe, Asia, Africa, South and Central America, and Mexico. Tables 4 and 5 illustrate the changes in country of origin of immigrants. Table 4 further illustrates that the greatest percentage increase has been in immigrants admitted from Asian countries.70/ The Asian population figures demonstrate a 1,000 percent increase in numbers of immigrants for the year 1977 as compared to the year 1965. In contrast, most European countries show a 50 to 70 percent decrease in numbers of immigrants in the year 1977 as compared to the year 1965.

Immigrants are admitted according to numerical limitations and on the basis of seven preference categories. Four of the categories pertain to reunion of families, two to occupational needs in the United States, and one to refugees. Numerical limitations allow a total of 290,000 immigrants and 17,000 refugees to be admitted each year. Certain new permanent resident aliens are exempt from numerical limitations. Therefore, the annual average number of immigrants admitted each year is approximately 400,000. In addition, certain refugee populations can be paroled into the United States if it has been determined that they are victims of certain catastrophic economic, political, or religious situations.71/ Because of the Southeast Asian situation, the number of those refugees the United States accepts has been temporarily increased to 168,000 per year.

70/ 1977 Annual Report: Immigration and Naturalization Service.

71/ Ibid., pg. 23.

Distribution of Immigrants and Refugees

Ten cities, which represent only about 10 percent of the total United States population, currently are receiving nearly 40 percent of all immigrants: New York City, Los Angeles, San Francisco, Chicago, Miami, Newark, Houston, El Paso, San Antonio, and Dallas. Table 6 lists the 10 most frequent destination cities of immigrants and the relative concentration of immigrants in these cities for 1975. The six States in which these cities are located account for almost 70 percent of today's immigrants. The distribution of immigrants today largely reflects the historical settlement patterns of immigrants in the United States. The study of the distribution of immigrants and refugees by State also confirms that they tend to concentrate in certain States. Table 7 identifies those States with a higher than average percentage of refugees.72/ Guam (17.0 percent) has 8 times the national average of 2.2 percent, and Hawaii (8.1 percent) has 4 times the national average of immigrants. However, the absolute number of aliens is greatest in California and New York, which jointly account for 42 percent of all resident aliens. California (33.2 percent) has more than 3 times the number of refugees than the next highest State. Table 8 illustrates that California, Texas, Pennsylvania, Washington State and Louisiana have the largest number of Indochinese refugees.73/

Based on these trends, immigrants coming to the United States in the future can be expected to head for major metropolitan areas where large foreign born populations have previously settled. Like the national population (see Table 9), today's immigrants also tend increasingly to go to southern and western States.

Immigrants tend to concentrate in ethnic neighborhoods. Often these neighborhoods are, or have been, designated as medically underserved. Medically underserved areas are target locations for federally funded primary health care clinics and frequently are located in the areas most likely to be utilized by immigrants. However, the availability of primary care services varies from community to community.

72/ 1976 Annual Report: Immigration and Naturalization Service.

73/ Annual Report on the Indochinese Refugee Assistance Program: 1979, Table 6.

Immigration accounts for 12 percent of the actual growth in the labor force each year.74/ The Asians who have immigrated since 1970, approximately 1.5 million people, come from 16 different ethnic groups of diverse history, culture, language, and religion.75/ In 1975, it was estimated that there were 11.2 million Hispanics in the United States, and that, by the year 2000, there will be approximately 55.3 million. The current Hispanic American population is composed of:

- 59 percent Mexican,
- 16 percent Puerto Rican,
- 6 percent Cuban,
- 7 percent Central and South American; and
- 12 percent other.76/

The number of undocumented aliens, the majority of whom are Mexican, varies, literally with the source of information. Most sources estimate there are 6 to 8 million undocumented aliens. Additionally, it is estimated that there are 25,000 Haitians in Florida, many of whom are undocumented.77/ Tables 10 and 11 list numbers of immigrants by country of origin and by country of birth. Of the top 10 countries, Mexico sends three to four times more immigrants than each of the other leading countries.78/

Health Care Reimbursement Needs of Various Immigrant Populations: The Impact on Public Health Care

It is necessary to assess the demands which the sheer numbers and distribution of immigrants place on the public health care system.

The data in this area are extremely sketchy. Earlier discussions have documented underutilization of services in relationship to need or health status by ethnic minorities and immigrants. Therefore, utilization-of-services data may not be an accurate measure of the immigrants' impact on public health services. Budgetary data or cost data also may not be useful in determining impact because they are not collected in relation to immigrant user/cost. As was stated in the introduction to this report, Hawaii is the only State which collects data on the health status of immigrants and refugees. Population data on the impact of immigration on public health services in other States are not available.

74/ "Immigrants and the American Labor Market", Manpower Research Monograph #31, United States Department of Labor, 1974, pg. 3.

75/ Yu, Elena, op. cit.

76/ Mental Health: 1978, op. cit., pg. 904.

77/ Human Services to Haitian Aliens, op. cit., 1978.

78/ Statistical Abstracts of the United States, 1978, op. cit., pg. 84 and 88.

However, local studies of specific populations have been undertaken and will be used in this section, but caution must be applied in any attempt to generalize these examples.

Undocumented Aliens

The December 1978, "Interim Staff Report of the Select Committee on Population" stated the following: "...despite popular belief, illegal immigrants do not appear to be a heavy burden on government programs. Undocumented aliens appear to be more likely to pay taxes than to use tax supported programs.... As far as can be determined, the incidence of receipt of welfare payments by illegal immigrants has been found to be relatively low. In fact, some suggest that illegal immigrants may actually subsidize the welfare system (especially the Social Security trust funds) because they pay more in taxes than they receive in benefits."79/

In addition, a study by the Orange County, California, Department of Health Task Force estimated that undocumented aliens in the county paid approximately $83 million in taxes, while only 9.6 percent received public medical services costing $2.7 million.80/

Refugees and Immigrants

Indochinese refugees are eligible for various public health services under the Indochinese Refugee Assistance Program (IRAP). In 1979, $137,400,000 was obligated to reimburse the States' Medicaid costs (usually 44 percent of total Medicaid costs) for cash assistance for needy refugees, for social services, and for related State and local administrative costs.81/ These programs served 248,436 Indochinese refugees. The socioeconomic status and English-language capability of the refugee decreased considerably between the 1975-77 migration and the 1978-79 migration. The percentage of the population receiving cash assistance reflects this change and is as follows:

Year	Percent of Population 82/
1975	11.89
1976	29.83
1977	34.60
1978	33.07
1979	37.34

79/ United States House of Representatives: Report Prepared by the Select Committee on Population: Legal and Illegal Immigration to the United States. Serial C, December 1978.

80/ Orange County, California, Department of Health Task Force on Undocumented Alien Usage of County Services. (n.d.)

81/ Annual Report on the Indochinese Refugee Assistance Program: 1979, op. cit.

82/ Ibid.

Approximately 15 percent of the refugee families are on cash assistance.83/ Their need for services should decrease as the resettlement process proceeds.

Refugees are eligible for services for three years, at which time their refugee status is adjusted to immigrant status; they are then no longer eligible for the refugee program. According to their age, economic status, or if women as heads of households, they may be eligible for further public assistance for health care through Medicare or Medicaid. Immigrants between the ages of 21 and 65, who are not disabled, are of a certain income level, and are either a single individual or a childless couple, usually are ineligible for Medicaid or Medicare. American citizens with the same qualifications also would be ineligible for Medicaid or Medicare. Federally funded primary care services, provided on a sliding-scale fee basis, are still available to such immigrants. Private funding or employer-provided health insurance benefits are two other mechanisms available to the immigrant for obtaining health care services.

Because of the multiple and variable provider systems, the impact of providing public health care is not well documented. However, Hawaii does have some data on this subject. In 1978, 26 percent of the immigrants in Hawaii financed their own health care, compared to only 9 percent of the residents. Only 27 percent of the immigrants in Hawaii were financed by Medicare/ Medicaid, while 43 percent of the residents were so financed.84/

In a study on Mexican Americans, it was concluded that they are four times as likely to receive medical treatment from primary health care services as the majority population.85/ In addition, populations having the lowest numbers of those covered by insurance were found to be the Hispanic populations, particularly the poor Hispanics.86/ This data, however, may not be generally applicable to the Hispanic immigrant populations.

83/ Ibid.

84/ Yuen and Juanasa, op. cit., pg. 16.

85/ Weaver, Jerry L., "Health Care Services in Orange County, California: A Socioeconomic Analysis", Long Beach: Center for Political Research, California State University, 1969.

86/ Health-United States: 1979. pg. 14.

A study of 1,608 Asian residents in America, from urban low-income neighborhoods, was conducted to examine their utilization of health care services.87/ This population, which has characteristics similar to recent Asian immigrants, used the following methods of payment for health care services as compared to personal health care expenditures for the Nation as a whole:

Study Group		Entire Population 88/	
Private Health Insurance	22.1%	Private Health Insurance	27.0%
Medicare	16.4%	Federal	27.7%
Medicaid	11.1%	State and Local	11.0%
		Philanthropy and Industry	1.3%
Direct-Borrowed Money	1.7%	Direct Payment	32.9%
Payment Savings	31.7%		
Still Owe for Care	2.1%		
Free	9.5%		
Other	5.4%		

To the extent that barriers to care are removed, it is expected that more people will receive health care services. The impact of expanding care coverage and its resultant costs also are issues of national concern. The extent of impact that the addition of new immigrant populations will or do have on the health care system is not known. The paucity of data makes projections of impact difficult.

87/ Asian American Field Study: Summary of the Data, op. cit., pg. 5.

88/ Annual Report on the Indochinese Refugee Assistance Program: 1979.

Current Efforts by the Department to Provide Adequate Services for Immigrant Populations

Although Congress specifically requested a report of the activities of the Bureau of Community Health Services (BCHS) in providing adequate health care services for immigrants, there are other programs within the Department which also contribute to providing such services. The Department is acutely aware of the barriers to health care experienced by medically underserved populations, including immigrants. Therefore, this section of the report will summarize the departmental programs, including BCHS programs, which provide health care services to populations which include immigrants.

Bureau of Community Health Services/Health Services Administration

Several programs within the Bureau are designed to reach those who are underserved or unserved by the existing health care system and to provide preventive, therapeutic, and rehabilitative ambulatory health care services to both urban and rural populations. The people served by the programs are primarily young, needy, and members of minority groups--people who otherwise might go without health care services. As of August 15, 1979, 7,473 areas in the United States had been designated as medically underserved. Of the estimated 51 million people living in these areas, 27 million are estimated to be medically underserved: 16 million in rural areas and 11 million in urban areas. The following are the programs of the Bureau which are most likely to be used by immigrants:

- Community Health Centers (CHCs) provide comprehensive primary care services. There are currently 872 CHCs which have the capacity to serve approximately 6.1 million people. Since 75 percent of all immigrants and refugees settle in urban areas, the Bureau's Urban Health Initiative (UHI) should improve the delivery of health care to them. The UHI supports and encourages development of integrated health care delivery systems in medically underserved urban areas through new approaches and concepts directed at combining, coordinating, and strengthening primary health care resources.

- Migrant Health Center projects concentrate on the health needs of migrant and seasonal farmworkers, many of whom are immigrants. The Health Financing Administration has concluded an agreement with the HSA to provide up to $4.2 million per year for reimbursement of hospitalization costs for migrant agricultural workers and their families.

- The Maternal and Child Health and Crippled Children's (MCH-CC) Services programs provide services to mothers and children, with primary emphasis on those living in economically depressed areas and on children who are crippled or who are suffering from conditions leading to crippling. The MCH-CC programs also fund special projects to improve pregnancy outcome in high-infant-mortality areas. The programs focus special efforts on integrating improved child health care programs with the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program administered through Medicaid.

- Comprehensive, voluntary family planning services are provided to persons desiring them, particularly low-income persons.

- The National Health Service Corps reaches the medically underserved by recruiting and placing health professionals (primarily physicians and dentists) in critical health manpower shortage areas.

All of the various primary care programs funded by the Bureau have the potential of serving immigrants. Several projects actually have a majority of clients who are recent immigrants or refugees. The BCHS primary care projects serving sizable numbers of immigrants employ bicultural/bilingual clinical and outreach staff. All projects are required to develop linkages with other appropriate public and private health service agencies in order to better coordinate service delivery. New federally funded primary care projects are encouraged in areas with high concentrations of immigrants. To assist in this effort, coordination with State and local governments, with the purpose of identifying areas of high immigrant concentration, will be continued and encouraged.

Some CHCs have collected data on their user populations which show the number of non-English-speaking users and/or numbers of immigrants. Virtually all of the Migrant Health Centers funded in the southwest border States (California, New Mexico, Arizona, and Texas) serve migrant farmworker populations who are predominantly Mexican-American, many of whom are recent immigrants. Additionally, CHCs are serving more Asian populations. This increased activity is due, in part, to immigrants settling in catchment areas which have centers already in operation, and because new projects for areas with Indochinese refugees are being funded.

Table 12 lists those BCHS projects which provide primary care services to sizable numbers of immigrants and refugees. These projects illustrate Bureau efforts made, to date, to serve the immigrant and refugee populations. It is expected that the projects in high impact areas will continue to serve these populations.

Bureau of Medical Services/Health Services Administration

Through formal agreements, direct medical services to Indochinese refugees have been provided by Public Health Service hospitals and clinics in an effort to offer assistance to State and local health departments and to voluntary agencies in the provision of requisite health services to refugees. The Social Security Administration and the Public Health Service also have reached an agreement to reimburse PHS for the costs of delivering such services to refugees. The Emergency Medical Service System is a regional program to establish emergency care capabilities nationwide, particularly in rural areas. This program applies to all eligible populations, including immigrants and refugees.

United States-Mexico Border Health Initiative

The Department is currently in the process of implementing the United States-Mexico Border Health Initiative. 89/ This initiative is an effort to improve the health status of populations on both sides of the border. Health data from both countries will be combined, compared, and used for planning in order to identify target areas with the most urgent need. The initiative calls for sister cities to be identified in order to assess needs and to develop complementary intervention programs. These two domestic programs must cooperate due to the international composition of their communities. A unilateral approach would not be appropriate as border migration is too extensive.

Center for Disease Control

The Center for Disease Control (CDC) is responsible for screening of all refugees and immigrants for excludable health conditions such as: venereal disease, active tuberculosis, infectious leprosy, and certain mental conditions. For refugees, screening has been provided in temporary holding camps overseas, with a visual inspection and medical records review at United States ports of entry. For immigrants, CDC sets standards, monitors overseas screening, and conducts a visual inspection and medical records review at ports of entry. The CDC has responsibility for quarantine services at ports of entry. The CDC also has worked to provide State and local health departments with prompt notification of refugees arriving within their areas of jurisdiction. The names of refugees -- along with the name, address and phone number of each refugee's sponsor -- are mailed to State and local health agencies within 24 hours of the refugees' arrival. The CDC also has instituted new procedures, to alert State and local health authorities about refugees entering their area who have non-infectious tuberculosis, by means of phone calls and special followup documentation.

89/ Review of the Health Situation, United States-Mexican Border and Recommendations for Bilateral Cooperation, 1978.

Additionally, the CDC conducts research, and publishes and distributes epidemiological data to health care providers, about potential and actual health needs of immigrants and refugees. It has implemented its immunization program for refugees overseas. There are plans to conduct research on the tuberculosis rate of refugees to determine its prevalence and impact on the rate in the United States and to make recommendations for prudent management by State and local health departments.

Alcohol, Drug Abuse, and Mental Health Administration

The Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) through the National Institute of Mental Health (NIMH), administers the Community Mental Health Center (CMHC) Program which is designed to provide comprehensive community-based mental health services for underserved populations. The BCHS primary care centers and the CMHCs have an interagency agreement to utilize each others' services in providing care to their clients. Alcohol and drug abuse programs, a part of ADAMHA, are also community-based. These three services are needed by immigrants and refugees. The NIMH also funds research projects on ethnic minorities and Indochinese refugees.

Although ADAMHA funded a number of special research programs concerning Indochinese refugee mental health during the first wave exodus in 1975-1976, it has recently recognized that there are significant differences in the current population of refugees immigrating to the United States. In December, ADAMHA organized a Refugee Work Group to plan and coordinate the agency's response to this new need. In the first phase of this planning effort, conducted in January 1980, the Refugee Work Group has organized a consultation study by nongovernmental mental health professionals and Indochinese community leaders to recommend actions to the agency. Followup activities in 1980 are expected to be as responsive as possible to the recommendations of this study.

Health Resources Administration

The Health Resources Administration (HRA) has responsibility for funding the training programs for health professionals and for administering the Health Planning Act of 1974 (P.L. 93-641, as amended by P.L. 96-79). The training programs, within the Bureau of Health Manpower, have the capability of identifying immigrant and refugee health professionals. Once identified, these professionals would need training to upgrade their medical knowledge in order to qualify for certification and licensure to practice in the United States. The HRA has the authorized capability and is providing funding for such training.

The Health Systems Agencies (HSAs) are responsible for assuring that communities develop plans for and begin to implement efforts to assure access, availability, and equity in health care for all. Because of this responsibility, HSAs are actively involved in planning services for any populations within their areas, including immigrants.

National Institutes of Health

The National Institutes of Health are the biomedical and health research agencies within the Department and, as such, would be responsible for research on specific diseases or disease processes which may be unique to the immigrant populations.

Health Care Financing Administration

The Health Care Financing Administration administers the Medicare and Medicaid programs. Through Medicare, Medicaid, and the new Refugee Assistance Program, the health care needs of many immigrants can be met within the mainstream delivery system for health care. The Medicare program can serve immigrants aged 65 and over have been lawfully admitted for permanent residence and who have resided in the country for 5 years.

Other immigrants are eligible for Medicare benefits because they have acquired "insured status" under the Social Security Administration's retirement, survivor, and disability insurance programs. Immigrants who are lawfully admitted for residence or who reside in this country under "color of law" are eligible for Medicaid benefits. States are required, under the revised Medicaid residency regulations, to provide Medicaid services to persons living in a State who have gone there to seek employment. This requirement covers migrant laborers. Special refugee assistance programs provide substantial help to Indochinese and other groups.

As mentioned earlier, the Medicare/Medicaid programs have two key constraints which affect provision of health care to immigrants. They do not provide services to undocumented aliens, and the Medicaid program does not provide Federal reimbursement to anyone, alien or citizen, who is between the ages of 21 and 65 who is not disabled and who is a single individual or childless couple.

National Center for Health Statistics and the National Center for Health Services Research

These two Centers are responsible for compiling and developing statistical data on health care services, on health status indicators, and on health care providers within the United States. They have developed and are implementing programs to improve assessment of health status and of health care for ethnic minorities, both citizens and immigrants. For example, a Health and Nutrition Examination Survey will be conducted on the various Hispanic populations with results to be reported in 1982 through 1985. Additionally, already collected data is being reanalyzed to provide statistical health information on various Asian populations, both citizens and immigrants.

Office of International Health

The Office of International Health (OIH) has been designated by the Assistant Secretary for Health and Surgeon General to take the lead among Public Health Service agencies in coordinating the Federal response to the health needs of refugees.

The OIH has established an interagency Refugee Working Group on Health (RWG/H) including representatives from Federal agencies and voluntary agencies involved in refugee health assistance. The OIH has provided two staff functions to the RWG/H for: (1) the Domestic Resettlement Program, and (2) the Kampuchean Refugee Relief Program. This staff also is responsible for coordinating all health activities domestically with the Office of Refugee Affairs, HEW, and internationally with the Kampuchean Work Group at the Department of State.

The RWG/H established a United States information and resource clearinghouse for volunteers seeking to assist in the international campaign to provide medical coverage at Thai camps serving Kampuchean refugees. The RWG/H staff also has developed a catalog of Public Health Service health professionals who can be called immediately to duty for overseas assignment if a Federal response is necessary in the Kampuchean refugee camps in Thailand. Finally, the RWG/H staff has begun to work closely with the PHS agencies involved in Indochinese refugee assistance to assure that these efforts are closely coordinated and effective.

RECOMMENDATIONS

The United States must develop a greater sensitivity to the health needs of immigrants and assure that those needs are addressed in national health planning efforts. Greater data collection, research, and focus on immigrant health needs are needed. The primary focus should be to identify underserved immigrant populations and facilitate their access to public and private health care services. A positive effort should be made to accommodate the special needs of immigrants within the existing health care system in a manner whereby self-sufficiency is encouraged and cultural integrity is maintained.

Congress has requested the Secretary to include in this report specific recommendations on the primary health care needs of immigrants. These recommendations are intended to be an initial endeavor.

Specific Recommendations

A. Research and Data Collection

A major obstacle to addressing the primary health care needs of immigrants is the lack of usable data. Collection and analysis of information which would provide an accurate morbidity/mortality profile of immigrants are hampered by an absence of uniform reporting procedures, both internationally and nationally. Epidemiological surveillance data of high immigrant-impact areas often are in an aggregate, nonethnic-specific form which is too broad to be useful in assessing the health care needs of immigrants.

1. Existing data sources should be utilized more effectively to gain information about immigrant populations. The effective utilization of data should include coordination of definitions and concepts, review of data for its applicability in determining immigrant needs, determination of validity, and inclusion of immigrant-specific items where appropriate.

2. Agencies currently involved in epidemiological surveillance (i.e., the National Center for Health Statistics, the National Center for Health Services Research, the Bureau of the Census) should collaborate and coordinate efforts on the collection of data for Federal, State and local use in the planning, development, and evaluation of primary health care services for immigrants. Such efforts should include data collection on health needs, utilization of health services, ethnicity and residency information, and other related topics.

3. Research and analysis should be undertaken to determine the following:

- o health needs (e.g., rates of morbidity, communicable diseases, mental illness of immigrant populations),
- o utilization and patterns of health care, and
- o the impact of sociocultural variables (e.g., language, traditional remedies and beliefs, the role of the community and family, means of obtaining information) on immigrant utilization of health services.

4. Written forms, literature, and directories of community services should be developed in the languages of the major immigrant populations.

5. Health Systems Agencies should include assessments of the needs of immigrants, and describe development of plans to meet these needs, in their Health Systems Plans and Annual Implementation Plans.

B. Delivery of Services

The following recommendations address the barriers to access of health care experienced by underserved populations, including immigrants;

1. The Department should continue to expand its internal linkages among primary health care services, mental health services, and social service agencies. These linkages create more comprehensive systems of services, all of which are needed by medically underserved populations which include immigrants.

2. Criteria for designation of a "high immigrant-impact area" should be developed and used in setting priorities for meeting immigrants' needs.

3. Health education programs undertaken for immigrants should incorporate the cultural and health beliefs of the immigrant population. These programs also should acquaint the immigrant population with the Western health care system, its concepts of disease and treatment (especially preventive medicine), and should include information to assist immigrants in using health insurance. The public schools, community centers, churches, and ethnic associations are possible locations for health education programs in addition to the usual health care provider locations.

4. In areas with large immigrant populations, primary health care projects should continue to implement services to remove linguistic and cultural barriers by hiring bilingual/bicultural professional staff, upgrading and using their services in the provision of care, and by training health aides who have cultural and language skills similar to those of the immigrants being served. At a minimum, inservice training programs about the culture and health traditions of the populations being served should be provided to all staff.

5. Communities with large immigrant populations should be targeted for technical assistance in the development and implementation of comprehensive primary health care programs for those populations. Communities, especially, need assistance in identifying Federal programs which can help meet local needs.

APPENDIX A

Appendix A

Sources and Contributors of Data
Used in this Report

A resource list of individuals involved with issues relating to the social and health care needs of immigrants in the selected States was developed. Areas interviewed were:

- Projects funded by the Bureau of Community Health Services (Community and Migrant Health Centers);
- Health Systems Agencies;
- State Health Planning and Development Agencies;
- Governors' Offices;
- State Health Departments;
- County Health Departments;
- The Office of Special Concerns, Office of the Secretary, Department of Health Education and Welfare;
- The Immigration and Naturalization Service;
- The Office of Family Assistance, Social Security Administration;
- Private social service agencies, and
- Private agencies concerned with immigrant interests.

CONFERENCE ON

THE PRIMARY HEALTH CARE NEEDS OF IMMIGRANTS

Dallas, Texas

June 12-13, 1979

List of Participants

Francis Chang
Executive Director
South Cove Community
Health Center
Boston, Massachusetts

Ed de la Cruz, M.W.S.
West Bay Filipino Direct
Services
San Francisco, California

Romel Dela Cruz
Health Planner
State Health Planning
Development Agency
Wailuku, Maui, Hawaii

Patrick H. DeLeon, Ph.D., MPH
Executive Assistant
Office of the Honorable
Daniel K. Inouye
Washington, D. C.

Hal J. Dewlett, M.D.
Regional Director of Public
Health
Texas Department of Health
Public Health Region 5
Arlington, Texas

Fred E. Diaz
Executive Director
Florida Community Health
Centers, Inc.
West Palm Beach, Florida

Sara G. Erlach
Health Program Advisor IV
California Department of
Health Services
Sacramento, California

J. L. Garcia-Gutierrez
Consultant
Pan American Health
Organization
Washington, D. C.

Estelle S. Gross
Research Assistant
Medicus Systems Corp.
Bethesda, Maryland

Marion L. Hanlon, M.S.
The Maui Medical Group
Wailuku, Maui, Hawaii

Bievenido D. Junasa
Director
State Immigrant Services
Honolulu, Hawaii

Richard F. Knobel
Project Director
Kaiser Foundation Health
Plan, Inc.
Honolulu, Hawaii

Emilio Lopez
Executive Director
Borinquen Health Care Center
Miami, Florida

Robert Malpepeai
Field Coordinator
San Francisco Mental Health
Training Center
San Francisco, California

Peggy Saika
Acting Director, Chinatown
Health Clinic
Chinatown Action for Progress, Inc.
New York, New York

The Honorable Patricia Saiki
Hawaii State Senator
Honolulu, Hawaii

Edward H. Stonis, M.D.
Chief, Pharmaceutical Services
Date County Department of
Public Health
Miami, Florida

Tom Surh, Esq.
Consulting Attorney
Korean Community Service
Center
San Francisco, California

Miguel Trevino
Project Coordinator
Laredo Migrant Health
Program
Laredo Webb County
Health Department
Laredo, Texas

Sophie Wong
Executive Director
North East Medical
Services
San Francisco, California

George A. L. Yuen
Director of Health
Hawaii State Department
of Health
Honolulu, Hawaii

Federal Representatives

Gerald Barton, M.D.
Acting Regional Health Administrator
DHEW Region VI
Dallas, Texas

Paul Bond
Section Chief
Primary Care for Florida and Kentucky
U.S. Public Health Service
DHEW Region IV
Atlanta, Georgia

Jerry Goodman
Regional Immigration Examiner
U.S. Immigration and Naturalization Service
Dallas, Texas

Barry R. Gordon
Regional Program Consultant for Community Health Centers
USPHS/DHEW
New York, New York

Blanche Keller
Deputy Associate Director for Migrant Health
Bureau of Community Health Services
Department of Health, Education and Welfare
Rockville, Maryland

Jon Rasmussen
Executive Officer
U.S. Public Health Service
DHEW Region IX
San Francisco, California

Jim Sliker
Regional Program Consultant for Community Health Centers
USPHS/DHEW
Boston, Massachusetts

Guest

Arthur Chen, M.D.
Family Practice Resident
Residency Program in Social Medicine
Montefiore Hospital and Medical Center
Bronx, New York

TABLES

TABLE 1

Percent of Population with Selected Social and Economic Characteristics, According to Race or Ethnicity: United States, Average Annual 1976-77

Social and Economic Characteristic	Race or Ethnicity			
	Black	Hispanic	Asian or Pacific Islander	White
	Percent of population			
Family income				
Less than $5,000	30	19	12	11
$5,000-$9,999	29	33	18	19
$10,000-$14,999	19	24	20	23
$15,000 or more	22	24	51	47
Educational attainment[1]				
High school graduate or more	50	42	78	70
College graduate	7	5	30	15
Employment status[2]				
Unemployed	12	9	8	6
Marital status[1]				
Married, spouse present	47	63	65	67

1 Persons 17 years and over.
2 Persons 17 years and over in the labor force.

NOTE: Racial and ethnic categories are mutually exclusive.
SOURCE: Division of Health Interview Statistics, National Center for Health Statistics: Data from the Health Interview Survey. Health-United States 1979: DHEW (PHS) No. 80-1232.

TABLE 2

Comparison of the Distribution of Manpower by Occupational Group Between Native Born, Foreign Born, and Immigrant Populations

OCCUPATIONAL GROUP	NATIVE BORN OF NATIVE PARENTS			Native Born of Foreign or Mixed Parentage	Foreign Born	1970 Immigrants at Entry	1970 Immigrants in 1972
	Total (1)	White (2)	Black (3)	(4)	(5)	(6)	(7)
Prof., Technical, and Kindred	14.6	15.5	8.1	15.6	15.5	29.4	17.8
Managers and Administrators	7.9	8.7	2.3	10.6	7.8	3.7	2.8
Sales Workers	6.9	7.6	2.3	8.4	6.6	10.5	2.0
Clerical and Kindred Workers	18.0	18.6	13.5	19.3	14.0		13.9
Craft and Kindred Workers	13.8	14.4	9.0	14.2	14.0	17.9	14.5
Operatives, Except Transport	13.6	13.0	18.2	12.4	18.3	11.7	20.7
Transport Equipment Operatives	4.1	3.9	5.8	3.3	1.9	----	----
Laborers, Except Farm	4.7	4.1	9.5	3.3	4.0	9.0	11.8
Farmers and Farm Managers	2.0	2.1	0.6	1.7	0.6	2.4	0.1
Farm Laborers and Foremen	1.3	1.1	2.4	0.7	1.7	2.8	2.0
Service Workers, Except Priv. House.	11.4	10.2	20.1	9.8	13.7	5.9	13.3
Private Household Workers	1.6	0.7	8.3	0.7	1.9	6.7	1.9

Source: North and LeBel, Manpower and Immigration Policies in the United States. Exhibit 13, 1978, p. 107.

TABLE 3

ESTIMATED 1985 OCCUPATIONAL DISTRIBUTION OF NET IMMIGRANT ADDITIONS TO U.S. CIVILIAN LABOR FORCE, AS COMPARED TO THE BLS 1985 OCCUPATIONAL NEEDS PROJECTIONS

(numbers in thousands)

Occupational Group	Net FY 1973-85 Immigrants (18-65) in U.S. Civilian Labor Force in 1985	Net Immigrants Arriving FY 1955-72 Under Age 18 Entering Labor Force 1973-85 Age 18-30	Total Immigrant Workers	BLS Projected Occupational Growth 1972-85	Immigrants as Percent of Occupational Growth	Fit Between Occupations of Immigrants and Projected Needs (see key below)
TOTAL*	2,342	547	2,889	21,697	13.3	
White Collar Workers	886	281	1,167	14,108	8.2	<
Professional and Technical Workers	433	85	518	4,541	11.4	=
Managers and Administrators	66	57	123	2,868	4.3	<
Salesworkers	53	33	86	946	9.1	<
Clerical Workers	334	106	440	5,853	7.5	<
Blue Collar Workers	1,049	178	1,227	5,124	23.9	>
Craft and Kindred Workers	315	73	388	2,990	13.0	=
Operatives	472	80	552	1,651	33.4	>
Nonfarm Laborers	262	25	287	583	49.2	>
Service Workers	366	78	444	3,634	12.2	=
Private Household Workers	46	5	51	-537	-	x
Other Service Workers	320	73	393	4,171	9.4	<
Farm Workers	44	10	54	-1,169		x

KEY:

< immigrants provide less than proportional share of occupational growth

= immigrants provide about the proportional share

> immigrants provide more than proportional share

x occupations for which a decline is projected

Source: North and LeBel (1978), Exhibit 14, p.109.

TABLE 4

Immigrants Admitted by Country or Region of Birth
Fiscal Years Ended September 30, 1977 and June 30, 1985

Country of birth	Number		Percent change
	1977	1985	
All countries	462,315	296,697	+55.8
Europe	70,010	113,424	−38.3
Austria	400	1,680	−76.2
Belgium	377	1,005	−62.5
Czechoslovakia	575	1,894	−69.6
Denmark	433	1,384	−68.7
France	1,618	4,039	−59.9
Germany	6,372	24,045	−73.5
Greece	7,838	3,002	+161.9
Hungary	853	1,574	−45.8
Ireland	1,238	5,463	−77.3
Italy	7,510	10,821	−30.6
Netherlands	1,014	3,035	−67.1
Norway	334	2,256	−85.2
Poland	4,010	8,465	−52.6
Portugal	9,657	2,005	+381.6
Romania	2,015	1,644	+22.6
Spain	2,487	2,200	+13.0
Sweden	571	2,411	−76.3
Switzerland	610	1,984	−69.3
U.S.S.R.	5,742	1,853	+209.9
United Kingdom	12,477	27,358	−119.3
Yugoslavia	2,791	2,818	−.96
Other Europe	1,688	2,438	−55.4
Asia	157,759	20,683	+652.7
China and Taiwan	19,764	4,057	+387.2
Hong Kong	5,632	712	+691.0
India	18,613	582	+3,098.1
Iran	4,261	804	+430.0
Japan	4,178	3,180	+31.4
Korea	30,917	2,165	+1,328.0
Pakistan	3,183	187	+1,602.1
Philippines	39,111	3,130	+1,149.6
Thailand	3,945	214	+1,743.5
Vietnam	4,629	226	+1,948.2
Other Asia	23,526	5,426	+333.6
North America	187,345	126,729	+47.8
Canada	12,688	38,327	−66.9
Mexico	44,079	37,969	+16.1
West Indies	114,011	37,583	+203.4
Cuba	69,708	19,760	+252.8
Dominican Republic	11,655	9,504	+22.6
Haiti	5,441	3,609	+50.8
Jamaica	11,501	1,837	+526.1
Trinidad and Tobago	6,106	485	+1,159.0
Other West Indies	9,600	2,388	+302.0
Other North America	16,567	12,850	+28.9
South America	32,954	30,962	+6.4
Argentina	2,787	6,124	−54.5
Brazil	1,513	2,869	−47.3
Colombia	8,272	10,885	−24.0
Other South America	20,382	11,084	+83.9
Africa	10,155	3,383	+200.2
Oceania	4,092	1,512	+170.6
Other countries	—	4	—

United States Department of Justice
Immigration and Naturalization Service

TABLE 5

Immigration and Naturalization

IMMIGRANTS, BY COUNTRY OF LAST PERMANENT RESIDENCE: 1820 TO 1977

[In thousands, except percent. For years ending June 30 except, beginning 1977, ending September 30. For definition of immigrants, see text, pp. 80-81. Data prior to 1906 refer to country from which aliens came. Because of boundary changes and changes in use of countries separately reported, data for certain countries not comparable throughout. See also *Historical Statistics, Colonial Times to 1970*, series C 89-119]

COUNTRY	1820-1977, total	1931-1960, total	1961-1970, total	1972	1973	1974	1975	1976	1977	PERCENT		
										1820-1977	1961-1970	1971-1977
Total	47,960	2,515.5	3,321.7	384.7	400.1	394.9	386.2	398.6	462.3	100.0	100.0	100.0
Europe	36,108	1,325.6	1,123.4	86.3	91.2	80.4	72.8	73.0	74.0	75.3	33.8	20.4
Austria [1]	4,314	67.1	29.6	2.3	1.6	.7	.5	.5	.5	8.9	.6	.3
Hungary		36.6	5.4	.5	1.0	.9	.6	.6	.8		.2	.2
Belgium	202	18.6	9.2	.5	.4	.4	.4	.5	.5	.4	.3	.1
Czechoslovakia	137	.9	3.3	1.2	.9	.4	.3	.3	.3	.3	.1	.2
Denmark	364	11.0	9.2	.5	.4	.5	.3	.4	.4	.8	.3	.1
Finland	33	4.9	4.2	.3	.3	.2	.2	.2	.2	.1	.1	.1
France	747	51.1	45.2	2.9	2.6	2.2	1.8	2.0	2.7	1.6	1.4	.6
Germany [2]	6,968	477.8	190.8	7.8	7.6	7.2	5.9	6.6	7.4	14.5	5.7	1.8
Great Britain [3]	4,879	195.5	210.0	11.5	11.9	11.7	12.2	13.0	14.0	10.2	6.3	3.1
Greece	646	47.6	86.0	10.5	10.3	10.6	9.8	8.6	7.8	1.3	2.6	2.6
Ireland [4]	4,722	57.3	32.5	1.4	1.6	1.3	1.7	1.0	1.0	9.9	1.1	.3
Italy	5,285	185.5	214.1	22.4	22.3	15.0	11.0	8.0	7.4	11.0	6.4	3.9
Netherlands	358	52.3	33.6	1.0	1.0	1.0	.8	.9	1.0	.8	.9	.2
Norway	856	22.9	15.5	.4	.4	.4	.4	.3	.3	1.8	.5	.1
Poland [5]	510	10.0	53.5	3.8	4.1	3.5	3.5	3.2	3.3	1.1	1.6	.8
Portugal	432	19.6	76.1	9.5	10.0	10.7	11.3	11.0	10.0	.9	2.3	2.6
Spain	254	7.9	44.7	4.3	5.5	4.7	2.6	2.8	3.6	.5	1.3	1.0
Sweden	1,271	21.7	17.1	.7	.8	.6	.5	.6	.6	2.7	.5	.2
Switzerland	348	17.7	18.5	1.0	.7	.7	.7	.8	.8	.7	.6	.2
U.S.S.R. [6]	3,387	.6	2.3	.4	.9	.9	4.7	7.4	5.4	7.0	.1	.7
Yugoslavia	111	8.2	20.4	2.8	3.2	3.0	2.9	2.3	2.3	.2	.6	.9
Other Europe	304	10.8	9.2	.6	1.9	1.8	1.3	2.0	2.0	.6	.3	.4
Asia	2,573	153.3	427.8	116.0	120.0	127.6	123.2	116.7	150.8	5.4	12.9	31.7
China [7]	510	9.7	34.8	8.5	9.2	10.0	9.2	9.0	12.5	1.0	1.0	2.4
Hong Kong	169	18.5	75.0	10.9	10.3	10.7	12.5	13.7	12.3	.4	2.3	2.8
India	140	2.0	27.2	15.6	12.0	11.7	14.3	16.1	16.8	.3	.8	3.5
Iran	33	3.4	10.3	2.9	2.9	2.5	2.2	2.6	4.2	.1	.3	.7
Israel	80	25.5	29.6	3.0	2.9	2.9	3.5	5.2	4.4	.2	.9	.8
Japan	400	46.3	40.0	5.0	6.1	5.4	4.8	4.8	4.5	.8	1.2	1.3
Jordan	34	5.8	11.7	2.4	2.1	2.5	2.3	2.4	2.9	.1	.3	.8
Korea	211	6.2	34.5	18.1	22.3	27.5	28.1	30.6	30.7	.4	1.0	6.1
Lebanon	46	4.5	15.2	3.0	2.6	3.0	4.0	5.0	5.5	.1	.5	.9
Philippines	343	19.3	98.4	28.7	30.2	32.5	31.3	30.8	38.5	.7	3.0	8.1
Turkey	344	3.5	10.1	1.5	1.4	1.4	1.1	1.0	1.0	.5	.3	.3
Vietnam	26	2.7	4.2	3.4	4.5	3.1	2.7	2.4	3.4	.1	.1	.8
Other Asia	197	9.0	36.7	11.0	13.5	13.8	13.2	10.2	14.1	.4	1.2	3.4
America	8,740	996.9	1,716.4	173.2	179.6	178.8	176.7	169.2	223.2	18.2	51.7	45.4
Argentina	89	19.5	49.7	2.5	2.9	2.9	2.8	2.7	3.1	.2	1.5	.7
Brazil	55	13.8	29.3	1.8	1.8	1.6	1.4	1.4	1.9	.1	.9	.4
Canada	4,077	378.0	413.3	18.6	14.8	12.3	11.2	11.4	18.0	8.5	12.4	3.9
Colombia	133	18.0	72.0	5.2	5.3	5.9	6.4	5.7	8.2	.3	2.2	1.5
Cuba	400	78.9	208.5	19.9	22.5	17.4	25.6	28.4	66.1	1.0	6.3	7.2
Dominican Rep.	194	9.9	93.3	10.8	14.0	15.7	14.1	12.4	11.6	.4	2.8	3.2
Ecuador	50	9.8	36.8	4.4	4.2	4.8	4.7	4.5	5.2	.2	1.1	1.2
El Salvador	38	5.9	15.0	2.0	2.0	2.3	2.4	2.4	4.4	.1	.4	.6
Guatemala	36	4.7	15.9	1.7	1.8	1.6	1.9	2.0	3.7	.1	.5	.5
Haiti	76	4.4	34.5	5.5	4.6	3.8	5.0	5.3	5.2	.1	1.0	1.2
Honduras	31	6.0	15.7	1.0	1.4	1.4	1.4	1.3	1.6	.1	.5	.3
Mexico	2,015	299.8	453.9	64.2	70.4	71.9	62.6	58.4	44.6	4.2	13.7	11.1
Panama	43	11.7	19.4	1.6	1.7	1.7	1.7	1.8	2.5	.1	.6	.5
Peru	42	7.4	19.1	1.5	1.8	2.0	2.3	2.6	3.9	.1	.6	.6
West Indies	684	29.8	133.9	24.2	21.6	24.4	22.3	19.6	27.1	1.4	4.0	5.9
Other America	657	99.2	106.2	8.3	8.8	9.1	8.9	9.3	10.1	1.3	3.2	2.5
Africa	119	14.1	29.0	5.5	5.5	5.2	5.9	5.7	9.6	.3	.9	1.8
Australia and New Zealand	116	11.5	19.6	2.6	2.5	2.0	1.8	2.1	2.5	.3	.6	.6
All other	304	14.0	5.7	1.2	1.3	1.4	1.8	1.9	2.2	.6	.2	.4

[1] 1935-1945, Austria included with Germany; 1850-1919, Poland included with Austria-Hungary, Germany, and U.S.S.R. [2] Beginning 1952, includes data for United Kingdom not specified, formerly included with "Other Europe." [3] Comprises Eire and Northern Ireland. [4] Europe and Asia. [5] Beginning 1957, includes Taiwan. [6] Prior to 1951, included with "Other Asia." [7] Prior to 1951, Philippines included with "All other." [8] Prior to 1953, data for Vietnam not available. [9] Prior to 1951, included with "Other America." [10] Prior to 1951, included with "West Indies."

Source: U.S. Immigration and Naturalization Service, *Annual Report*.

TABLE 6

The Most Frequent Destination Cities of Immigrants and the Relative Concentration of Immigrants in These Cities: 1975 */

City	Number Arriving 1975 Immigrants	Percentage of 1975 Immigrants
New York	73,630	19.1
Los Angeles	18,338	4.7
Chicago	17,083	4.4
Miami	14,503	3.8
San Francisco	8,486	2.2
Honolulu	4,917	1.3
Houston	4,059	1.0
Newark	3,278	0.8
El Paso	3,032	0.8
Philadelphia	2,954	0.8
TOTAL	150,280	38.9

*/ North and LeBel - Manpower and Immigration Policies in the United States. Exhibit 8, p. 8., 1978.

TABLE 7

The Number and Percent of Concentration of Immigrants in the States With Higher Than the National Average Number of Resident Aliens - 1976. */

State	Immigrants Per State Population	Registered Alien Population: 1976	% Immigrants in 7 Most Frequent Destination States
Guam (territory)	17.0%	15,855	–
Hawaii	8.1%	68,144	–
California	5.6%	1,179,276	26%
Florida	4.6%	389,775	7%
New York	4.3%	764,664	17%
New Jersey	3.7%	266,906	6%
Rhode Island	3.3%	30,002	–
Massachusetts	3.0%	172,033	4%
Connecticut	3.0%	93,111	–
Texas	2.9%	350,053	8%
Illinois	2.6%	281,770	6%
Total Resident Alien Population: 1976	2.2%**	4,775,559	74%

** Percent of U.S. population which are immigrants.

*/ Annual Report: Immigration and Naturalization Service - 1976.

TABLE 8

Estimated Indochinese Refugee Population in States With Greater Than 3,000 Refugees: September 30, 1979*/

	State	Estimated Population	
1.	California	82,382	
2.	Texas	24,534	
3.	Pennsylvania	10,198	
4.	Virginia	7,596	
	Washington, D.C.	2,356	12,670
	Maryland	2,827	
5.	Washington (State)	9,204	
6.	Louisiana	8,521	
7.	Illinois	8,082	
8.	Virginia	7,596	
9.	New York	6,539	
10.	Oregon	6,445	
11.	Minnesota	6,081	
12.	Florida	5,610	
13.	Colorado	5,280	
14.	Michigan	4,260	
15.	Oklahoma	4,081	
16.	Iowa	3,832	
17.	Hawaii	3,781	
18.	Ohio	3,435	
19.	Wisconsin	3,157	
20.	Kansas	3,195	
	All other States	37,040	
TOTAL		248,436	

*/ Annual Report on the Indochinese Refugee Program. December, 1979.

TABLE 9

Population and Percent Distribution, According to Race or Ethnicity, Region, and Place of Residence: United States, Average Annual 1976-77

Population, Region, and Place of residence	Race or Ethnicity						
	Black	Hispanic				Asian or Pacific Islander	White
		Total[1]	Mexican	Puerto Rican	Cuban		
	Number in thousands						
Population	23,066	11,913	7,206	1,739	774	2,951	160,129
	Percent distribution						
Geographic region	100	100	100	100	100	100	100
Northeast	18	21	1	80	32	18	25
North Central	20	8	7	9	3	11	30
South	54	30	36	5	56	12	28
West	8	42	56	6	9	59	18
Place of Residence	100	100	100	100	100	100	100
SMSA	76	84	79	95	98	93	67
Central city	57	48	42	74	44	47	24
Outside central city	19	35	37	21	53	46	43
Outside SMSA	24	16	21	5	*2	8	33

[1] Includes others of Hispanic origin not shown as a separate category.

NOTE: Racial and ethnic categories are mutually exclusive.

SOURCE: Division of Health Interview Statistics, National Center for Health Statistics: Data from the Health Interview Survey. Health-United States: 1979 DHEW(PHS) 80-1232.

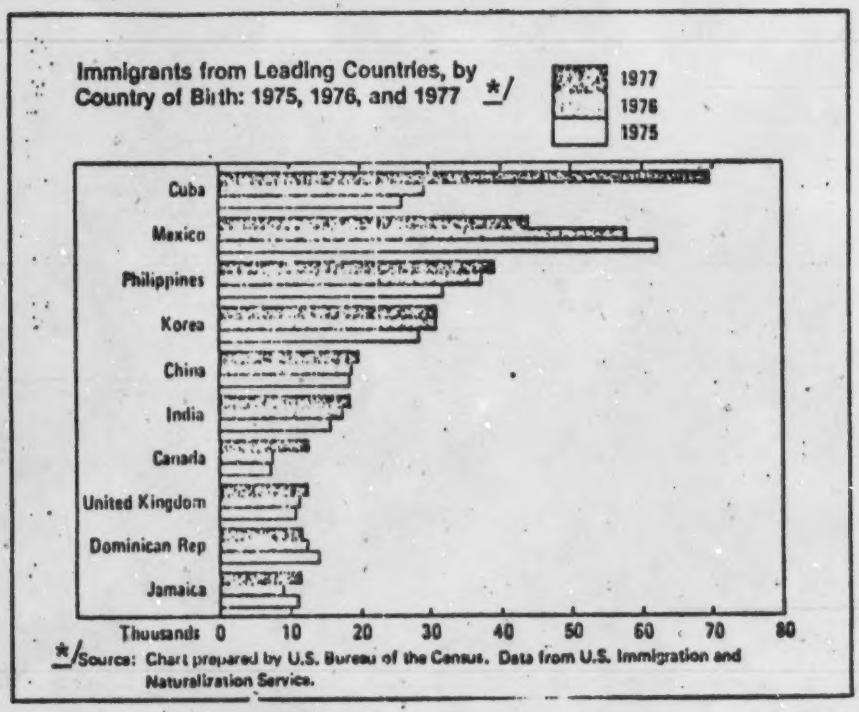
TABLE 10

Number of Immigrants (Resident Aliens Only) by Country of Origin in the United States: 1977 */

Country	Number
Mexico	938,972
Cuba	311,188
Canada	305,475
United Kingdom	287,320
Philippines	203,971
Italy	196,761
Germany	162,764
Korea	130,492
China and Taiwan	121,312
Portugal	120,101

*/ Annual Report: Immigration and Naturalization Service - 1977.

TABLE 11



*/Source: Chart prepared by U.S. Bureau of the Census. Data from U.S. Immigration and Naturalization Service.

Bureau of Community Health Services Programs
Which Provide Primary Care Services to
Sizable Numbers of Immigrants and Refugees: 1979

Community Health and Migrant Health Center Programs
(and Sites With Integrated National Health Service Corps (NHSC) Assignees)

West End Community Health Center
Bridgeport, Connecticut

Providence Ambulatory Health Care, Inc.
Providence, Rhode Island

South Cove Community Health Center
Boston, Massachussetts

Chinatown Health Clinic
New York, New York

East of the River Health Association
Washington, D.C.

Shaw Community Health Program
Washington, D.C.

East Baltimore Medical Program
Baltimore, Maryland (also NHSA)

North Central Baltimore Health Corp.
Baltimore; Maryland (also NHSC)

Park West CHC
Baltimore, Maryland (also NHSC)

South Baltimore Family Health Care
Annapolis, Maryland

West Baltimore Community Health Corp.
Baltimore, Maryland (also NHSC)

Hamilton Health Center
Harrisburg, Pennsylvania

Comprehensive Health Services Plan, Inc.
Philadelphia, Pennsylvania (also NHSC)

Covenant House Health Services
Philadelphia, Pennsylvania (also NHSC)

Philadelphia Group Mental Health/
Mental Retardation Association
Scranton Primary Health Care Center
(Affiliated with Bishop E. Wright
Memorial Health Center, Philadelphia,
Pennsylvania)
Scranton, Pennsylvania

Spring Garden Family Health Center
Philadelphia, Pennsylvania (also NHSC)

Rural Health Care Corporation of
Northeastern Pennsylvania
Wilkes Barre, Pennsylvania

Franklin Memorial Primary Health Center
Mobile, Alabama

Family Oriented Primary Care Program
Mobile County Health Dept.
Mobile, Alabama

Community Health Services Federation, Inc.
Birmingham, Alabama

Lister Hill Health Center
Health Services, Inc.
Montgomery, Alabama

Augusta Family Oriented Primary Care
Project
Augusta, Georgia

Atlanta Southside CHC
Atlanta, Georgia

West End Medical Center
Atlanta, Georgia

Intercity CHC
Savannah, Georgia

Westside Comprehensive Health Center, Inc.
Savannah, Georgia

Community Health and Migrant Health Center Programs (continued)

Urban Health Center of Savannah, Inc.
Savannah, Georgia

Economic Oppo tunity Health Center
Miami, Florida

Community Health of South Dade, Inc.
Miami, Florida

Borinquen Health Care Center
Miami, Florida

Coconut Grove Family Clinic
Miami, Florida

Miami Beach Community Health, Inc.
Miami, Florida

Park Duvalle CHC
Louisville, Kentucky

Louisville Memorial Hospital
Louisville, Kentucky

Hunter Foundation for Health Care, Inc.
Lexington, Kentucky

Covington Family Health Center, Inc.
Covington, Kentucky

Franklin C. Fetter Family Health Center
Charleston, South Carolina

Lincoln CHC
Durham, North Carolina

Wake Health Services, Inc.
Raleigh, North Carolina

Knox Co. Ambulatory Care Program
Knowville, Tennessee

Tennessee Dept. of Public Health
Knoxville, Tennessee

North Memphis CH Organization
Memphis, Tennessee

Memphis Health Center, Inc.
Memphis, Tennessee

Upper Cumberland Regional Office
Nashville, Tennessee

Upper Cumberland Region Primary Care Project
Nashville, Tennessee

Bradley-Grundy-Marion-Meigs Counties
Nashville, Tennessee

Hancock Co. Primary Care Center
Nashville, Tennessee

Sara Land Development Corp.
Gulfport, Mississippi

Biloxi Health & Social Services
Biloxi, Mississippi

Teche Action Board
Franklin, Louisiana

Fourth Ward Clinic
Houston, Texas

Palo Pinto Community Health Services, Inc.
Mineral Wells, Texas

North Central Texas Medical Foundation
Wichita Falls, Texas

New Orleans Health Corp. Community Project
New Orleans, Louisiana

Arkansas Family Planning Council
Little Rock, Arkansas

Community Health Centers of Dallas
Dallas, Texas

Health Center of Pulaski County
Little Rock, Arkansas

Zawala Community Health Association
Crystal City, Texas

Centro deSalud Familiar LaFe
El Paso, Texas

Los Barios Community Clinic
Dallas, Texas

A Family Health Care Delivery Model
San Antonio, Texas

Su Clinical Familiar
Harlingen, Texas

Fourth Ward
Houston, Texas

Albuquerque Primary Health Care System
Albuquerque, New Mexico

Centro Campesino deSalud in Espanola
Albuquerque, New Mexico

San Luis Valley CHC
Alamosa, Colorado

Wayne Miner Neighborhood Health Center
Kansas City, Missouri

Swope Parkway Community Health Center
Kansas City, Missouri

St. Louis Comprehensive Health Center
St. Louis, Missouri

Omaha North Eastern Health Services
Omaha, Nebraska

Community Health Care, Inc.
Davenport, Iowa

Denver Health and Hospital Neighborhood Health Center
Denver, Colorado

Pueblo Community Health Center
Pueblo, Colorado

Colorado Community Health Center
Colorado Springs, Colorado

Utah Family Health Program Community Health Center
Salt Lake City, Utah

Weber County Community Health Center
Ogden, Utah

Salt Lake City Community Health Center
Salt Lake City, Utah

Mission Area Health Association
San Francisco, California

Centro deSalud de las Communidad de San Ysidro
San Ysidro, California

Community Health Foundation of East Los Angeles
Los Angeles, California

North East Medical Services
San Francisco, California

Watts Health Center Comprehensive Health Services
Los Angeles, California

East Oakland Family Health Center
Oakland, California

County of Orange Human Services Agency Public Health & Medical Services
Santa Ana, California

Department of Health, State of Hawaii
Honolulu, Hawaii

Wainal District Coast Comprehensive Health and Hospital Board
Wainal, Oahu, Hawaii

Kokua Halihi Valley Health Center
Oahu, Hawaii

Kaiser Permanente Medical Group
Oahu, Hawaii

Community Health and Migrant Health Center Programs (continued)

Hale Ho'la Hou (Kalihi-Palama Walk-in Clinic)
Oahu, Hawaii

Waikiki Health Center
Oahu, Hawaii

Kalihi-Palama Mental Health Center
Oahu, Hawaii

Health Care Delivery System of Multnomah County
Portland, Oregon (also NHSC)

Cry of Love, Inc.
Salem, Oregon (also NHSC)

Central Seattle Community Health Centers (International District Community Health Center and SEA-MAR Community Health Center)
Seattle, Washington (also NHSC)

National Health Service Corps Programs

Uptown People's Health Center
Chicago, Illinois

Central Seattle Community Health Centers (Country Doctor Clinic, Carolyn Downs Family Medical Clinic, and Pike Market Community Clinic)
Seattle, Washington

Neighborhood Health Centers of Seattle, Inc. (High Point Community Centers, Holly Park Medical Clinic, Rainier Vista Community Health Clinic, and Yesler Terrace Medical Clinic)
Seattle, Washington

John Wesley Health Center
Los Angeles, California

Free Standing Sites

Hempstead, Texas

Westville, Oklahoma

Gillette, Arkansas

Van Buren, Arkansas

Des Ark, Arkansas

Foreman, Arkansas

Cotton Plant, Arkansas

W. Memphis, Arkansas

Maternal and Child Health Programs

Department of Human Resources
Washington, D.C.

Virginia Department of Health
Richmond, Virginia

Maternal Health Services Northeastern Pennsylvania
Kingston, Pennsylvania (FP)

Chicago Department of Health
Chicago, Illinois

New York State Department of Health
(Statewide)

Multnomah County (C&Y Project)
Portland, Oregon

Colorado Maternal and Child Health Centers (Statewide)

California Department of Health (delivered through local health departments - Statewide)

Maternal and Child Health services are delivered through local health departments in the States listed below. In addition, Maternal and Infant Care (M&I), Children and Youth (C&Y), Intensive Infant Care (IIC), Sudden Infant Death Syndrome (SIDS), Mental Retardation (MR), Family Planning (FP), Improved Pregnancy Outcome (IPO), and Crippled Children's services are delivered by university centers. Services are provided in the following cities:

Alabama
- Mobile (M&I, IIC, SIDS)
- Dothan
- Birmingham (M&I, C&Y, IIC, MR)
- Montgomery (MR, FP)
- Selma (FP)
- Huntsville (IIC)

Florida
- Pensacola (ICC)
- Ft. Walton Beach
- Panama City
- Tallahassee
- Jacksonville (Dental)
- Tampa (MR)
- St. Petersburg
- Orlando (M&I)
- Miami (M&I, C&Y, MR)

Florida - (Primarily Greater Miami)
- Dade County
- Boringer Health Care Center

- Dade County
- Family Health Center

Mississippi
- Gulfport
- Biloxi
- Pascagoula

Georgia
- Atlanta (M&I - Grady, IPO, IIC - De Kalb, MR project and hypertension)
- Savannah (Child Evaluation Center)
- Columbus (IPO)
- Augusta (M&I, C&Y, IPO)

Tennessee
- Memphis
- Nashville
- Marfreesboro
- Knoxville

North Carolina
- Fayetteville (MIC)
- Charlotte
- Winston-Salem (MIC)
- Greensboro (C&Y)
- Raleigh
- Durham

Maternal and Child Health Programs (continued)

South Carolina
Spartanburg
Columbia
Charleston

Kentucky
Louisville (MR, C&Y)
Lexington (IIC)
Covington
Owensboro

Statewide: 1. Family Planning
2. Crippled Children's Services

Texas - Delivered through local health departments in Houston, Galveston, Dallas Fort Worth, San Antonio, Austin, Beaumont, Corpus Christi, Dalhart, Amarillo

New Mexico - Delivered through local health departments in Albuquerque, Santa Fe, Clovis, Los Alamos

Louisiana - Delivered through parish health departments in Orleans, Caddo, Calcasieu, E. Baton Rouge, Jefferson Davis, Lafayette, Ouachita, Rapides, St. Tammany, Vernon, Washington

Arkansas - Delivered through local health departments in Pulaski County (C&Y), Pope County (Dental, M&I, FP), Sharp County, Arkansas County, Jefferson County, Sebastian County, Chicot County, Craighead County.

APPENDIX B

APPENDIX B

BIBLIOGRAPHY

Alero, Jose. Puerto Ricans & Health: Findings from New York City, Fordham University, Bronx, New York, June 1978.

American Public Health Association. Minority Health Chart Book, 1974.

Anderson, Ronald; Aday, Luann; Chin, Grace; Lewis, Sandra Zelman and Giachello, Aida L. "Access to Medical Care Among the Latino Population of the Southwestern United States." Paper presented at the American Public Health Association Meetings, Los Angeles, California, October 16, 1978.

Barrett-Connor, Elizabeth. "Latent and Chronic Infections Imported from Southeast Asia." JAMA, May 5, 1978, pg. 1901-1905.

Bernal, Martha E. and Karen J. Jamieson. "Caretaker-Client Ethnicity Effects." Paper presented at meetings of the American Public Health Association, Los Angeles, California, October, 1978.

Buggs, Vernon M. Chicanos & Rural Poverty. The Johns Hopkins University Press, Baltimore, 1973.

Bullough, B. "Poverty, Ethnic Identity and Preventive Health Care." Journal of Health & Social Behavior. 13(December): 347-359, 1972.

Bullough, Bonnie and Vern Bullough. Poverty, Ethnic Identity and Health Care. Appleton - Century - Crofts, New York, 1972.

Burch, Thomas A. Hawaii State Department of Health, Research and Statistics Office. Health of Residents, Immigrants, and Immigrants in Hawaii, 1973: A Report Based on the Hawaiian Health Survey. April, 1977.

Burch, Thomas A. "Health of Residents, Immigrants and Immigrants in Hawaii, 1973," RNS Report #14, April 1977.

Burch, Thomas M.D. "Public Health Nursing Services to Immigrants & Residents in Hawaii, 1976-1977 Fiscal Year." Report #21. Research and Statistics Office, Hawaii State Department of Health, March, 1978.

Burma, John, ed. Mexican-Americans In the United States: A Reader. Schenkman Publishing Company, Inc., New York, 1970.

a) Madsen, William. "Society and Health in the Lower Rio Grande Valley." pg. 329-342.

b) Karno, Mariom & Robert B. Edgerton, "Perception of Mental Illness in a Mexican-American Community." pg. 343-354.

c) Dworkin, Anthony. "Stereotypes & Self Images Held by Native-Born and Foreign-Born Mexican-Americans." pg. 398-410.

Chang, Francis and Stephen Tang. "A Neighborhood Health Center; One Communities Solution." Civil Rights Digest. (Fall): 19-23, 1977.

Clark, Margaret. Health in the Mexican-American Culture: A Community Setting. Los Angeles: University of California Press, 1970.

"Differential Trends in Mortality Among Border Populations: 1950-1970." Paper presented at the 36th Meeting of the United States-Mexico Border Health Association, Reynosa, Tamaulipas, Mexico. April 16-19, 1978.

Grotberg, Edith, ed. 200 Years of Children. US. DHEW, Office of Human Development, Office of Child Development, 1976.

Grebler, Moore and Guyman. The Mexican-American People. (n.d.)

____. Guide to Immigration Benefits, (available from GPO).

____. Hawaii State Immigrant Services Center, Commission on Manpower and Full Employment. Evaluation Report of the Kalihi-Palama Immigrant Service Center. August, 1974.

Hawthorne, Berkley C. "Refugee Policy Action Items: Mental Health. " Memorandum to Refugee Policy Group Chairman, December 21, 1978.

____. Kalihi-Palama Interagency Council for Immigrant Services, Inc. Directory of Services Available to Immigrants in Kalihi-Palama, June, 1977.

Hayes-Bautista, Ph.D. "Latino Health Conditions: Policies for Future Research (Draft)." Berkley, California: School of Public Health (n.d.)

Health Planning Council for Greater Boston, Inc. "Review of Health Problems and Barriers to Health Care of Hispanic Population Groups." by Boston University Center for Health Planning under DHEW Contract No. HRA 232-78-0108, 1978.

Hoppe, S.K. and P.L. Heller. "Alienation, Familism and the Utilization of Health Services by Mexican-Americans." Journal of Health and Social Behavior. 16(3): 304-314, 1975.

----. Identification of Problems in Access to Health Services and Health Careers for Asian Americans, 1976. Prepared by JWK International Corporation under Contract No. HRA - 230-75-0193.

____. Immigrants in Hawaii - 1977, March, 1978.

Johnson, David B. and Charles Portwood III, "Estimates of State of Hawaii Health Costs by Major Service and Source of Funding: July 1, 1976 - June 30, 1977" State Health Planning and Development Agency, March, 1979.

Junasa, Bienvenido D. "Asian Immigrants--Adjustment and Integration." Journal of Asian-Pacific and World Perspectives. 2(summer): 15-26, 1978.

Kim, Bok-Lim C. and Margaret E. Condon. A Study of Asian Americans in Chicago: Their Socio-Economic Characteristics, Problems and Service Needs. Supported by funding from the National Institute of Mental Health, Grant No.1 R01 MH 23993-01. (n.d.)

Kim, Bok-Lim C. "Service Needs of Asian Immigrants as Seen by the Ethnic Churches: Korean Example." University of Illinois. August, 1973.

Kitans, Harry, Ph. D. and Tom Owan, M.S.W. "Japanese and Korean Responses to Health Needs in Los Angeles." funded by the Institute for Social Science Research, U.C.L.A., and the U.C.L.A. Health Service Research Center (n.d.)

Kitzinger, Sheila D. Litt. "Challenges in Antenatal Education." Nursing Mirrow. 144(June 23): 19-22, 1977.

Kleinman, Arthur, gen. ed. Medicine in Chinese Cultures: Comparative Studies of Health Care in Chinese and Other Societies. Bethesda, Maryland: National Institutes of Health, Publication No. (NIH) 75-653, 1975. Chapter 21: "An Integrated Approach in the Delivery of Health Care to a Chinese Community in America" by Albert C. Gaw.

Kotin, Joseph. "California Asian Communities are Seething with Crime." The Washington Post, Feb. 13, 1980, pg. 1A-6.

Lee, Isaiah, C. Dr. P.H. Medical Care In a Mexican-American Community, CA: Hwong Publishing Co., 1976. p.10.

Mosely, J. Edward and Byron L. Spice. The Spanish-Speaking People of the Southwest, Council on Spanish American Work. 1966.

Moulton, David M. "The Socioeconomic Status of Asian American Families in Five Major SMSAs," March 9. 1978.

North, D. and A. LeBel. Manpower and Immigration Policies in the United States, Report prepared for the National Commission for Manpower Policy, Feb. 1978.

Pian, Canta. "Asian and Pacific American Women's Health Concerns." Unpublished paper presented to Women and Health Roundtable, DHEW, OASH, ASPE, OSC, Division of Asian American Affairs, September 14, 1978.

____. "Public Policy Responses to the Health Needs of Pacific/Asian American Families." Paper presented at the Conference on Pacific and Asian American Families and HEW-Related Issues, Airlie, Virginia, March 9-12, 1978.

Quesada, Gustavo M. "Language and Communication Barriers for Health Delivery to a Minority Group." Social Science and Medicine. 10 (June): 323-327, 1976.

Reichmen, Lee , Chairman. Ad Hoc Committee of the Scientific Assembly on Tuberculosis. "Tuberculosis is in the Foreign Born." American Review of Respiratory Disease. 116:561-564, 1977.

____. Review of the Health Situation: United States--Mexico Border and Recommendations for Bilateral Cooperation. (A Joint Effort of the United States, Mexico and the Pan American Health Organization),1978.

Ross, Stanley. Views Across the Border: The United States & Mexico. University of New Mexico Press, Albuquerque, 1978.

____. "Reports and Comments: Mexican Migrants Medical Care Review. Vol. 36, No.9, October, 1979.

Segal, Julius and Norman Louries. "The Mental Health of the Vietnam Refugee." Report of NIMH, June 8, 1975.

Silverman, Marsha. "Vietnamese in Denver: Cultural Conflicts in Health Care." (Paper presented at the Conference on Indochinese Refugees, George Mason University). october 25, 1979.

South Texas Systems Agency. South Texas Health Systems Agency Health Systems Plan 1979-1983. Kingsville, Texas: July, 1978. Prepared under DHEW Contract No. 06-P-00211-01.

____. Summary and Recommendations: Conference on Pacific and Asian American Families and HEW-Related Issues, March 9-12, 1978. Prepared by JWK International Corporation under Contract No. HEW 100-77-0102.

Task Force on Human Services for Haitian Aliens. Human Services to Haitian Aliens. Miami , Florida: Metropolitian Dade County, County Manager's Office, 1978.

Teller, Charles and Steve Cyburn. "Mortality, Morbidity and Other Health Status Indicators of Chicanos in Texas." Austin: The University of Texas, July, 1974. (Unpublished report).

The President's Commission on Mental Health: 1978 Volume III, Appendix: Task Panel Reports Submitted to the President's Commission on Mental Health. Report of the Subpanels on "Special Populations: Minorities, Women, Physically Handicapped." "Asian/Pacific Americans." "Hispanics."

Thomas, M.A. "The Effects of a Cultural Awareness Program on the Delivery of Health Care." Health and Social Work. 2(3): 123-36, 1977.

True, Reiko Homma. "Health Care Issues for Asian Americans." ADAMHA, PHS. (unpublished report), July, 1979.

____. UN: Department of Economic and Social Affairs. The Determinants and Consequences of Population Trends. Population Study #50, 1973.

U.S. Department of Commerce, Bureau of the Census. Statistical Abstract of the United States, 1978.

U.S. Department of Commerce. Persons of Spanish Origin in the United States; March, 1978. Current Populations Report, June, 1979.

U.S. Department of Commerce, Bureau of the Census. Persons of Spanish Origin in the United States: March 1978, Population Characteristics.

U.S. Department of Health, Education and Welfare. Health - United States: 1978. DHEW (PHS) No. 78-1232.

U.S. Department of Health, Education and Welfare. Health - United States: 1979, DHEW (PHS) No. 80-1232.

U.S. Department of Health, Education and Welfare, Health Resources Administration, Office of Health Resources Opportunity. Health of the Disadvantaged: Chartbook. September, 1977. DHEW Publication No. (HRA) 77-628.

U.S. Department of Health, Education and Welfare, Office of the Secretary, Office of Special Concerns, Division of Asian American Affairs. Asian American Field Survey: Summary of the Data. May 1977. (available from GPO).

U.S. Department of Health, Education and Welfare, Public Health Services, Bureau of Community Health Services. "Meeting the Health Care Needs of Our Nation's Immigrants." Regional Offices Responses to Memorandum dated February 22, 1978. (unpublished).

U.S. Department of Health, Education and Welfare, Public Health Service. "Review of BCHS Efforts to Insure and Provide Adequate Health Services for our Immigrant Population." 1978. (unpublished).

U.S. Department of Health, Education and Welfare, Public Health Service. Public Health Service Hospitals AdHoc Committee: Report to the Secretary. August 31, 1978.

U.S. Department of Health, Education and Welfare, Public Health Service, Comprehensive Work Plan for Refugees. December 6, 1979 (unpublished report).

U.S. Department of Health, Education and Welfare, National Center for Health Statistics. Vital and Health Statistics, Series 10. No. 113, 1973-74.

U.S. Department of Justice, Immigration and Naturalization Service. 1976 Annual Report: Immigration and Naturalization Service. (available from GPO).

U.S. Department of Justice, Immigration and Naturalization Service. 1977 Annual Report: Immigration and Naturalization Service. (available From GPO)

U.S. Department of Justice, Labor and State. Interagency Task Force on Immigration Policy Staff Report. March, 1979

U.S. Departments of Justice, Labor, and State. Interagency Task Force on Immigration Policy: Staff Report Companion Papers. August, 1979.

U.S. Department of Labor. Immigration and the American Labor Market: Manpower Research Monograph #31 , 1974.

Weaver, Jerry L., Ph.D. National Health Policy and the Underserved: Ethnic Minorities, Women, and the Elderly. St. Louis: Mosby Co., 1976.

Weaver, J.L. "Health Care Service Use in Orange County California: A Socioeconomic analysis." Long Beach: Center for Political Research, California State University, 1969.

Welch, Susan, John Comer, and Michael Steinman. "Some Social and Attitudinal Correlates of Health Care Among Mexican Americans." Journal of Health and Social Behavior. 14(September): 205-213, 1973.

____. World Population Growth and Response 1965-1975: A Decade of Global Action. Population Reference Bureau, Inc. 1976.

Yeh, Samuel D.J., M.D., Sc.D.: McSweeney, James, M.D.: and Shiu, Man Hei, M.D. "Schistomiasis Japanica of Liver." New York State Journal Of Medicine. 77(March): 366-369, 1977.

Yuen, George and Bienvenido Junasa. "Preliminary Report: Immigration in Hawaii." (unpublished report presented at the Dallas Conference on the Primary Health Care Needs of Immigrants). June, 1979.

United States House of Representatives: Report Prepared by the Select Committee on Population. Legal and Illegal Immigration to the United States. Serial C, December, 1978.